DOUGLAS COUNTY
HEALTH AND SOCIAL SERVICES

May 1, 2011

Tom Engle
Department of Human Services
800 N.E. Oregon Street, Suite 930
Portland, OR 97232

Dear Mr. Engle:

Enclosed please find Douglas County's Public Health Annual Plan for 2010/2011, which is being submitted pursuant to ORS 431.385. This plan has been prepared according to your instructions and assures that the activities defined in ORS 431.375 - 431.385 and ORS 431.416 are performed. If you have any questions or need further information, please contact me at (541) 440-3625.

Douglas County submits this Annual Plan with the understanding that various staff, programs, and plans will be evolving or be eliminated to match state and federal funding available come July 1, 2011. At this time we plan to provide public health services as outlined in this annual plan. We will continue to work with CHLO on how to provide public health services with limited funding.

Sincerely,

Peggy Madison

Digitally signed by Peggy Madison
DN: cn=Peggy Madison, o=Douglas County Health and Social Services, ou=Health Administrator, email=pemadison@co.douglas.or.us, c=US
Date: 2011.04.22 11:15:42 -07'00'

Peggy Madison, Administrator
Douglas County Health and Social Services

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I. EXECUTIVE SUMMARY

Douglas County Health and Social Services (DCHSS) is a steward of public health in Douglas County and is responsible for local leadership in the promotion of policies, systems, and environments that promote health and prevent illness, disease and injury. Accordingly, DCHSS defines its public health responsibilities by the nationally recognized Ten Essential Public Health Functions, which describe what every person, regardless of where they live, can reasonably expect from their Local Public Health Authority. These Functions provide foundation for Public Health in Douglas County and Oregon.

1. Monitoring health status to identify community health problems
2. Diagnosing and investigating identified health problems and health hazards in the community
3. Informing, educating, and empowering people about health issues
4. Mobilizing community partnerships to identify and solve health problems
5. Developing policies and plans that support individual and community health efforts
6. Enforcing laws and regulations that protect health and ensure safety
7. Linking people to needed personal health services and assuring the provision of health care when otherwise unavailable
8. Assuring a competent public health and personal health care workforce
9. Assessing effectiveness, accessibility and quality of personal and population-based health services
10. Researching for new insights and innovative solutions to health problems

Douglas County's expansive geography and rural demographics require the use of different strategies to fulfill the essential public health functions than used in urban areas. The economy of scale that helps to ensure that these essential functions are accomplished in urban areas does not exist in Oregon's rural jurisdictions. As a consequence, competing priorities, fiscal constraints, and our distance from technical and research centers impose limitations on our capacity to address complexity of each essential function.

Douglas County, as with many rural jurisdictions, faces the challenges of an aging population, high rates of unemployment and poverty, few educational opportunities, high rates of tobacco and other drug use, and fewer local resources dedicated to addressing these and other known health risk factors. Approximately, 70 percent of Douglas County's population lives outside of central Roseburg core area. The scarcity of health care coverage and the concentration of health services in core area are made worse by limited public transportation, long travel distances, and limited availability of health care specialists.

The most difficult obstacle in providing public health services is inadequate funding. County public health programs have historically relied on federal funding. In 2009-2010, Douglas

County experienced a 10 percent reduction in safety net funding. The County Board of Commissioners directed the Public Health Division to cut approximately 35% or $300,000 from the Public Health Division budget. With reduced general fund support, the Douglas County Health Department will rely more on state funding, grant monies, Medicaid-match programs, and revenue from service provided. There is no local property tax funding to support public health. Douglas County government continues to evaluate plans on how to increase revenue, streamline programs, and cut non-essential services.

Douglas County submits this Annual Plan with the understanding that staff, programs, and plans will evolve or be eliminated to match state and federal funding available on July 1, 2011. The Health Department will continue to work with CHLO to identify priorities and develop plans to provide public health services without adequate funding.

II. ASSESSMENT

The following indicators provide a description of the public health issues and needs in Douglas County.

Geography

Douglas County extends west to east from sea level at the Pacific Ocean to 9,182-foot Mt. Thielsen in the Cascade Range. Douglas County covers an expansive 5,071 square miles. Douglas County is comprised of 12 incorporated cities Canyonville, Drain, Elkton, Glendale, Myrtle Creek, Oakland, Reedsport Riddle, Roseburg, Sutherlin, Winston, and Yoncalla. About 70% of the County's population lives in cities and unincorporated areas outside of the Roseburg core area – areas designated by the Oregon Office of Rural Health as areas of Unmet Health Care Need.

Population

According to Oregon's 2010 Census report, Douglas County's population has grown to 105,240, up from the county's 2000 Census count of 100,240 (Portland State Population Research Center, 2010 Census Data for Oregon). Forecasts based upon 2000 Census data predict that Douglas County's population will grow to over 117,000 by 2017. The 2010 population estimates by age show the following age demographic: 0-17 (20.9%), 18-64 (59.6%), and 65 and over (19.5%) (2010 Certified Estimate). Approximately 20% of Douglas County's population is between the ages of 4 and 20.

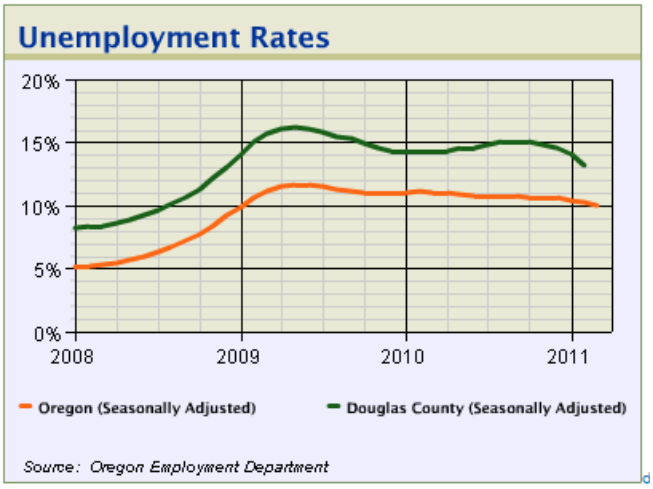
According to 2009 Douglas County Census estimate, 94.3% of the county's population is white non-Hispanic, as compared to 89.8% statewide. Approximately 4.3% of Douglas County's population is Hispanic/Latino, followed by 1.6% American Indian, .8% Asian/Pacific Islander, and .4% African American.

Income and Poverty

The national economic crisis has hit Douglas County hard, and the impact of the decline in the County's timber and wood products industries cannot be overstated. The effects of the decline reverberate throughout the community, particularly since there are few other jobs in the area with comparable pay and benefits for workers with relatively low education levels, unlike urban areas with more diversified economies.

According to the 2009 Douglas County Census estimate, 14.2% of Douglas County's population is below the Federal Poverty Level (FPL), as compared to 13.5% statewide. The recently released 2010 Children First for Oregon reports that 26% of children under age 18 in Douglas County live below the FPL poverty level, as compared to 19.6% statewide.

The economic difficulty faced by many Douglas County families is further reflected in local income and unemployment data. Data from the national County Health Rankings show an unemployment rate of 15.4% in Douglas County, as compared to 11.1% statewide the percent of the civilian labor force, age 16 and older, that is unemployed but seeking work.



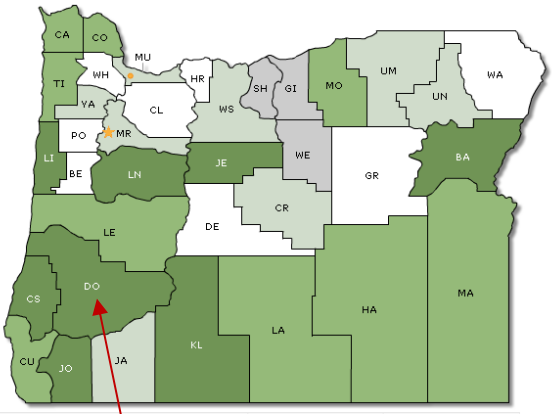
According to data compiled in the 2010 Children First for Oregon report, the median family income is $50,600 in Douglas County, 18% lower than the state median. Approximately 4.5 per 1,000 people filed for personal bankruptcy in 2009, a 111% increase since 2006. 71.8% of public school children were eligible to receive free/reduced price lunches during the school year.

County Health Rankings

The recently released 2011 County Health Rankings report by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation provides a snapshot of counties throughout the U.S. on various health indicators. Researchers used a variety of measures to assess the level of overall health or ***health outcomes***: the rate of people dying before age 75, self-reported fair or poor health, poor physical health days, poor mental health days, and the percent of births with low-birth weight. As compared to other counties in Oregon, Douglas County is ranked very low on overall health outcomes—a ranking of 31 out of 33. Sample indicators contributing to Douglas County's overall health ranking include:

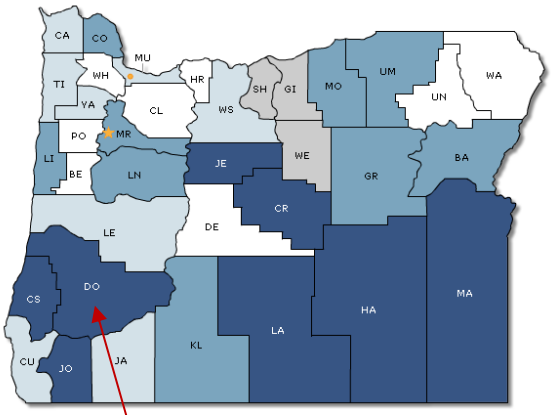
The overall ***health factors*** ranking is based on various factors that influence the health of communities, such as health behaviors (e.g., tobacco use, physical activity, obesity, teen pregnancy), clinical care (e.g., uninsured adults, access to health care providers, diabetic screening, social and economic factors (e.g., education, children in poverty, unemployment, income, crime), and the physical environment (e.g., air quality, access to healthy foods, liquor store density). Douglas County ranked 31 out of 33 on overall health factors**.** Sample indicators contributing to Douglas County's overall health factors ranking include:

2011 Health Outcomes



Baker (BA) - 29	Douglas (DO) - 31	Lake (LA) - 21	Sherman (SH) - NR
Benton (BE) - 1	Gilliam (GI) - NR	Lane (LE) - 18	Tillamook (TI) - 24
Clackamas (CL) - 4	Grant (GR) - 6	Lincoln (LI) - 27	Umatilla (UM) - 15
Clatsop (CA) - 17	Harney (HA) - 20	Linn (LN) - 28	Union (UN) - 11
Columbia (CO) - 19	Hood River (HR) - 2	Malheur (MA) - 23	Wallowa (WA) - 5
Coos (CS) - 26	Jackson (JA) - 13	Marion (MR) - 10	Wasco (WS) - 9
Crook (CR) - 14	Jefferson (JE) - 33	Morrow (MO) - 22	Washington (WH) - 3
Curry (CU) - 25	Josephine (JO) - 30	Multnomah (MU) - 16	Wheeler (WE) - NR
Deschutes (DE) - 7	Klamath (KL) - 32	Polk (PO) - 8	Yamhill (YA) - 12

2011 Health Factors



Baker (BA) - 18	Douglas (DO) - 31	Lake (LA) - 29	Sherman (SH) - NR
Benton (BE) - 1	Gilliam (GI) - NR	Lane (LE) - 11	Tillamook (TI) - 13
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Alcohol, Tobacco, and other Drug Use

Alcohol, tobacco and other drug use affects families, schools, workplaces, and entire communities. Most current data available from the 2010 Oregon Student Wellness Survey, show that alcohol, tobacco and other drug use is higher among Douglas County youth and adults than among youth and adults statewide.

Alcohol Use: Most recent data show that 23.2% of 8th graders and 36.8% of 11th graders reported drinking alcohol on one or more occasions in the past 30 days, as compared to 22.5% and 36.3% statewide. Of youth who report drinking alcohol, 11% of eighth graders and 21.4% of 11th graders report binge drinking (5 or more drinks in a row within a couple of hours).

Tobacco Use: Tobacco use among Douglas County youth continues to be significantly higher than among youth statewide. Data from 2010 Student Wellness Survey show that 12.6% of 8th graders and 15.5% of 11th graders smoke cigarettes, as compared to 8.2% and 14.3% respectively statewide.

Marijuana Use: Data show that 12.1% of 8th graders and 19.5% of 11th graders in Douglas County report use of marijuana. Data from the Oregon Medical Marijuana Program show that as of April 1, 2011, there were 1,581 medical marijuana patient cardholders in Douglas County, representing approximately 4% of all patient cardholders statewide. Although the potential medicinal properties of marijuana are under investigation, concern has been expressed by the

Whitehouse National Drug Control Policy office that the increase in use of marijuana as medicine may be contribute to a "softening of attitudes" about marijuana use by youth.[1] The following tables from the 2010 Student Wellness Survey illustrate factors that contribute to alcohol, tobacco and marijuana use by children: perception of harm and perception of parent disapproval.

Perception of Moderate or Great Risk

Table 30: Perception of Moderate or Great Risk

	Grade 6		Grade 8		Grade 11	
	N	Pct	N	Pct	N	Pct
Take one or two drinks of an acoholic beverage (beer, wine, liquor) nearly every day	329	67.2	661	60.2	509	61.9
Smoke one or more packs of cigarettes a day	327	84.7	653	85.5	505	84.8
Smoke marijuana once or twice a week	325	87.1	658	73.9	503	64.4

Percentages exclude missing answers.

Parents Feel It Would Be Wrong or Very Wrong

Table 31: Parents Feel It Would Be Wrong or Very Wrong

	Grade 6		Grade 8		Grade 11	
	N	Pct	N	Pct	N	Pct
Drink beer, wine or liquor regularly	337	96.1	669	88.6	508	75.2
Smoke cigarettes	335	98.8	667	96.1	508	90.6
Smoke marijuana	335	98.2	663	94.4	506	89.9

Percentages exclude missing answers.

Tobacco Use: While most adults in Douglas County do not smoke, the prevalence of adult smoking continues to be significantly higher in Douglas County (27.3%) than among adults statewide (18.7%) (Oregon Tobacco Facts and Laws, 2011).

Tobacco use among pregnant women in Douglas County continues at an alarmingly high rate. The most recent data show that one in four infants (25%) are born to women who report using tobacco during pregnancy, as compared to 12% statewide (Oregon Tobacco Facts and Laws, 2011).

Economic status is the single greatest predictor of tobacco use in the United States and in Oregon. In Oregon, 13% of insured adults smoke, as compared to 33% adults who are uninsured, and 37% of adults who receive Medicaid/Oregon Health Plan. Data show that disparities in tobacco use are even higher in Douglas County, where an estimated 45% of uninsured adults and 48% of people who receive Medicaid/Oregon Health Plan use tobacco.

Tobacco costs Oregon nearly $2.4 billion dollars in direct medical costs and indirect costs of lost productivity due premature death (Oregon Tobacco Facts & Laws, 2011). The cost to Douglas County alone is $115 million, and a significantly higher tobacco-related death rate (225/100,000), as compared to the statewide rate (178/100,000).

Physical Activity, Diet, and Obesity

Nationally, obesity affects 17% of all children and adolescents – 3 times the rate from just one generation ago. According to the Oregon Health Improvement Plan, obesity in Oregon adults

[1] White House Office of National Drug Control Policy statement in response to release of 2010 Monitoring the Future Survey, Community Anti-Drug Coalition of America, 12/16/2010.

has increased 121 % since 1990, and jumped 54% among middle and high school students in the years between 2001 and 2009. Data from the Oregon Healthy Teen Survey, 2007-2008 and Oregon Health Improvement Plan, 2011-2020 show that overweight and obesity continue to be a problem in Douglas County.

Overweight and Obesity in Douglas County			
	8th Grade	11th Grade	Adults (18+ years)
Overweight	28%	28%	37%
Obese	12%	14%	28%

Many factors play a role in increased rates of overweight and obesity, including poor nutrition and physical inactivity. In Douglas County only 20.7% of 8th graders, 14.6% of 11th graders, and 26% of adults in Douglas County eats the recommended 5-a-day fruits and vegetables per day. Similarly, only 62% of 8th graders, 51% of 11th graders, and 57% of adults meets the recommended level of physical activity.

Health Care Coverage

The vast majority of communities in Douglas County are designated by the Oregon Office of Rural Health as areas of unmet healthcare need. According to the 2011 County Health Rankings report, the ratio of population to primary healthcare providers in Douglas County is 1,301:1 population, as compared to the national benchmark of 631:1. Twenty-one percent (21%) of children under age 18 are living in poverty in Douglas County, as compared to compared to 18% statewide. Sixteen percent (16%) of adults are uninsured, as compared to the national benchmark of 13%. Data from the Oregon Healthy Teen Survey, 2007-2008 shows that 79% of Douglas County 8th graders and 78.3% of 11th graders reported having an unmet physical health care need.

Safety net medical services are available in Douglas County through Umpqua Community Health Center (UCHC). UCHC is a Federally Qualified Health Center (FQHC) located in Roseburg, with satellite clinics in Glide, Drain, and Myrtle Creek. In 2007, the FQHC became a delegate agency under the County's Immunization Program, which opened up free vaccine to 317 eligible clients at the FQHC and opened up free vaccine to the underinsured VFC eligible clients seen at the county health department. At this time, the FQHC is providing immunizations at their Roseburg site, and in limited amounts at their satellite clinics, Roseburg High School Based Health Center, and Douglas High School Based Health Center. During this last year another Federally Qualified Look Alike Clinic has been added in the community of Winston, entitled South River Medical. This clinic provides family comprehensive health care by a physician, nurse practitioner and behavioral health counselor.

Douglas County has three hospitals within its borders; the Roseburg Veteran's Affairs Medical Center, Mercy Medical Center, and Lower Umpqua Hospital.

Chronic Disease

Chronic diseases are the major causes of disability and death for Oregonians. The leading chronic disease in Douglas County continues to be cancer, followed by heart disease, cerebrovascular disease and chronic lower respiratory disease. According to the 2011 County Health Rankings report, 22% of Douglas County adults report fair or poor health, as compared to 14% statewide. Data from the Oregon Health Authority show that the prevalence of many chronic conditions is significantly higher in Douglas County than statewide.

Age Adjusted	Stroke	Diabetes	Arthritis	Heart Attack	High BP
Oregon	2.3%	6.5%	26.9%	3.5%	32.3%
Douglas	3.7%**	8.5%**	35.7%**	5.6%**	36.4%

Keeping Oregonians Healthy, 2004-2007 data updates

Although tobacco-related cancers have declined in Oregon, Douglas County has a consistently higher incidence of tobacco-related cancer (lung and bronchial) than statewide. Mortality due to tobacco-related cancer is significantly higher in Douglas County than statewide. Data show approximately 225 deaths per 100,000 in Douglas County each year, as compared to 178 per 100,000 statewide.

Conversations about improving health often turn to counseling or education to motivate individuals to eat well, get regular exercise, or quit smoking. While counseling and education are important, where we live may have a greater influence on how we live and how healthy we are. Over the past year, the Cow Creek Band of Umpqua Tribe of Indians and Douglas County Public Health Division have partnered on a *Healthy Communities* assessment project to learn what is working in Douglas County to improve health and where improvements are possible. More information about the Douglas County Healthy Communities project is available online at http://www.co.douglas.or.us/health/ph/HealthyActive.asp.

Oral Health

Oral health care is simply out of reach for many uninsured and underinsured children and adults in Douglas County. Consequently, many are at an increased risk for periodontal infection, tooth loss, and more serious health problems that result from or co-occur with dental disease. According to the Oregon Smile Survey of 2007 nearly two in three (64%) children in Oregon in first, second, and third grades have already had a cavity, and 58.4% of children ages 1-4 have not received any Preventive Dental Care in the past year. In Douglas County this number increases to 78.6% by the time students reach the 8th grade (Oregon Healthy Teen Survey, 2007-2008).

Douglas County is designated by the Health Resources & Services Administration (HRSA) as a dental health care shortage area. The ratio of population to dentist was last reported to be over 10,000 to 1 and contiguous county resources are inaccessible or excessively distant.

Community water fluoridation is one of the safest, least expensive, most effective and simplest ways to fight tooth decay. Oregon ranks 48th out of 50 states for water fluoridation. Douglas County does not have community water fluoridation. The Public Health Division supports the fluoridation of community water supplies to reduce tooth decay.

In January and February 2008, DCHSS Public Health Promotion conducted a brief phone survey of fourteen Douglas County preschools and found that only one of the fourteen provides dental education as part of its daily program activities. As a result of this survey, the Public Health Division hosted an Oregon State University Public Health Intern to develop a Dental Health Education toolkit to provide to the 14 preschools that participated in the survey and to the Douglas County Babies First! and Healthy Start programs.

Douglas County is one of four Oregon counties working in cooperation with the University of Washington Dental School on a Baby Smiles project to promote oral health among pregnant women and their children. To date, Douglas County has successfully enrolled 102 Medicaid eligible pregnant women in the Baby Smiles project and is entering Phase 2 (postpartum phase).

Youth Development and Education

Data from the 2010 Children First for Oregon show that 83.7% of 3rd graders and 66.7% of 8th graders met or exceeded the state standards for reading. Approximately 91.9% of students complete high school. Approximately 81% of Douglas County residents 25 years of age and older are high school graduates, as compared to 85.1% statewide. Only 13.3% of Douglas County residents hold a Bachelor's degree or higher, as compared to 25.1% statewide (2008 U.S. Census for Douglas County).

Maternal and Child Health

Teen pregnancy rates in Douglas County are 7.3/1,000 births to teens ages 10-17 compared to statewide at 7.1 /1,000 births to teens ages 10-17 (Oregon Teen Pregnancy Data, 2010 YTD), and 19.2 in Douglas County (15-17) compared to 18.0/1000 statewide. These numbers continue to represent an increase in teen pregnancy in Douglas County over the past few years. Other maternal and child health indicators of concern in Douglas County include the rate of low birth weight babies 2010 was 82.3/1,000 births, as compared to 62.5/1,000 births statewide (Oregon Vital Statistics 2010). One in four women (25%) in Douglas County report using tobacco during pregnancy, as compared to 12.2% statewide (DHS Tobacco Facts, 2009).

Abuse and Neglect

According to the 2010 Children First for Oregon report, 1,370 reports of child abuse, neglect, threat of harm were made in this area in 2009. Of cases reported, 52% of these reports were assessed, and 12% were founded. A total of 430 children in Douglas County are reported to have been in foster care at least once during the past year. Data for 2009 show that 42.6.2% of

founded abuse/neglect/threat of harm referrals were related to domestic violence and 60.5% were related to substance abuse.

Local Health Department Basic Services

The mission of DCHSS is to assist residents and visitors in Douglas County to be healthy, independent, and safe. DCHSS administers and enforces state and local public health rules and laws, and works to promote policies, systems and environments that promote health and prevent disease and injury.

DCHSS provides the five basic services outlined in ORS 431.416 and related Administrative Rules. The basic services and functions are performed in a manner consistent with Minimum Standards for Local Health Departments, adopted by the Conference of Local Health Officials.

Inadequate funding to Public Health continues to jeopardize our ability to deliver services necessary to promote and protect public health. In fiscal year 2004-2005, the DCHSS Public Health Division had a budget that supported 64.7 FTE. In fiscal year 2008-2009, the Public Health Division will have an expected staffing of 49.8 FTE. In 2009-2010 the FTE decrease to 43.0. In Fiscal Year 2010/2011 the FTE will decreased to 41.1, and in Fiscal Year 2011/2012 will be reduced to 34.90 FTE's. With a reduction in staff comes a reduction in services, reduction in revenue, and a reduction in matching funds. Continued reductions will have a far-reaching impact on our ability to perform the functions of Public Health Programs and our ability to respond to Douglas County most pressing public health issues.

Adequacy of Core Services

Oregon Administrative Rule 333-014-0050 establishes that each county and district health department shall perform (or cause to be performed) all of the duties and functions imposed upon it by Oregon Revised Statutes, and by official administrative rules adopted by the State Health Division and filed with the Secretary of State. These duties and functions shall be performed in a manner consistent with Minimum Standards for Local Health Departments, adopted by the Conference of Local Health Officials (CLHO). The following program areas shall be considered essential, and be specifically included in the overall annual plan of each county and district health department who shall assure programs are available.

1. Epidemiology and control of preventable diseases and disorders:

   It is difficult to sustain a minimally adequate response to epidemiology and control of preventable diseases when State funding has been reduced or is unpredictable, and County Public Health Programs rely on grant funding and County general fund dollars. In addition, DCHSS has been already impacted by budget cuts at the state level, with greater budget cuts expected in 2011-2012. DCHSS receives no State funding specific to control of Sexually Transmitted Diseases, only in-kind donations of medications. The State funding for Tuberculosis for 2010-2011 at $3,506 does not fully fund the activities to investigate and

manage the County's TB cases. In addition, HIV Prevention funding from the State is unpredictable with Oregon counties coming on or off the funding formula from year to year, making it difficult to plan for long term goals and sustainable activities. DCHSS is expecting a 41.62% decrease in State HIV Prevention funding from 2010-2011 to 2012-2013. In addition, if the Governor makes proposed budget cuts for 2011-2013, DCHSS could lose the entire contract award with the Oregon Immunization Program for $28,845. All of these reductions, impact the public health of the citizens of Douglas County.

The Board of Commissioners for three years in a row has directed that all Divisions in the Health Department that have county general fund support reduce the safety net dollars in the budget by 10%. For fiscal year 2011-2012, the instructions have been to reduce the safety net dollars by another 35%. To frame the dollar reductions in a different picture, DCHSS budgeted the Communicable Disease, STD, TB, HIV, and Immunization Programs with 8.22 FTE in 09-10, 7.32 FTE in 10-11, and will be again reduced to 5.42 FTE in the 11-12 budget. For Public Health to deal with epidemiology and control of preventable diseases, additional funding and staffing is required to adequately address public health priorities, reinstate Public Health programs, and meet national and state benchmarks.

2. Parent and child health services, which includes family planning:

   Funding cuts to Public Health in the 2009-2010 budget mean the elimination of the Healthy Start Program (4.0 FTE's); 1- CHN3 position in support of the Prenatal Clinic; and 1 – CHN4, management position for Family Planning. In 2010-2011 the nursing workforce will again be reduced by another FTE. In 2011/2012 the nursing staff again will be reduced by 1.0 contracted outstationed nursing position at DHS and 2.0 FTE within the Field Staff Unit.

   These cuts have a ripple effect on other programs. The reduction of a field staff nurse position not only means a struggle to meet Babies First! and Maternity Case Management program goals, but reduces our capacity to cover clinical services (e.g., immunizations, STD, HIV, Family Planning, or Communicable Disease).

3. Collection and reporting of health statistics: - Rosemarie

   Birth and death reporting, recording, and registration are provided by the DCHSS Roseburg office. In 2006, DCHSS implemented electronic death registration with funeral homes. Only one county physician participates in electronic death registration. DCHSS implemented electronic birth certificates in January 2008.

   The Deputy Registrars at the Douglas County satellite Health Department offices (located in Canyonville, Drain and Reedsport) receive and send to the State applications for in-state and out-of-state birth certificate copies for clients of the Contraceptive Care (CCare Program) only. While the remote-located Deputy Registrars are able to notarize the application for birth certificate forms, employees neither process nor register the birth with the State of Oregon. Applications for birth certificate copies are: (a) accepted from CCareP

clients as part of the program eligibility requirements, (b) notarized if necessary, (c) sent to the State and, upon return from the applicable State (d) a copy of the birth certificate is forwarded to the applicant, if requested. The birth certificate copy is then reproduced by the Deputy Registrar and the copy is sent to the Medical Records department (with the electronic medical record number assigned) for inclusion in the CCare client's electronic medical record.

The following organization/staffing changes were implemented during the past year:

a. The Douglas County Registrar position became vacant and a new Registrar was appointed effective 02/07/2011.

4. Health information and referral services:

DCHSS provides accurate and unbiased information and referral about local health and human services to the citizens of Douglas County. Information and referral is provided through response to telephone inquiries, providing information and referral information through news releases, presentations, printed materials, the County's website, community meetings and task groups, and by communicating in-person with DCHSS clients.

5. Environmental health services:

Environmental health resides as a program within Public Health. The programs focus has narrowed over the last several years to ensure that public facilities licensed under the authority granted to us by the Oregon Public Health Authority meet established standards of Public Health. The three primary components of this program are: licensed facilities, epidemiology, and public drinking water. We also provide technical consultation services to communities within the county that address a verity of environmental health issues. The licensed facilities and drinking water components of our program are fee or contract based and the epidemiological component (primarily rabies) is funded through pass through dollars from the State. In 2007-2008 the fee structure was changed for Benevolent Temporary Food Service Licenses. No other fee adjustments have been made for the rest of the programs since 2003. An evaluation of the Environmental Health fee structure has been completed and was found to be underfunded by approximately $99,000. The Board of Commissioners has tentatively agreed to raise licensed facility fees this year. Program fees are expected to continue to increase due to the expected loss of federal timber safety net dollars. The other two programs, epidemiology and drinking water underfunded by an additional $22,000.

Adequacy of Other Public Health Services

The Douglas County Public Health Division has, in the past, provided a number of services of importance to the health of Douglas County, including health education and promotion, oral

health promotion and outreach, older adult health education, and other important public health services. Continued budget cuts to the Public Health Division reduce our capacity to provide many of the programs and services that promote the health of our community. The following describes the other services provided under OAR 333-014-0050 during fiscal year 2011-2012.

1. Emergency preparedness including participation in the development of Douglas County's emergency response plans and internal procedures necessary to carry out the local health department role in the plans.

    a. Douglas County Public Health reviews plans written by the DCHSS Preparedness Coordinator to ensure coordination with Public Health resources and plans. Douglas County Public Health employees are trained in ICS 100 and 700; staff is trained in higher level Incident Command courses as appropriate. Douglas County Public Health participates in countywide preparedness exercises. The Public Health Promotion Program Manager has received advanced training to fulfill the role of the local health department Public Information Officer.

2. Laboratory services including providing diagnostic and screening tests to support public health services which are in compliance with quality assurance guidelines established by the State Health Division.

    a. Douglas County Public Health has lab services that provide supportive services primarily to the Family Planning, WIC, and HIV/STD clinics. The lab is a moderate, high complexity Clinical Laboratory Improvement Amendments certified lab, authorized to perform bacterial, mycological, & parasitological testing. During the 2011/2012 Fiscal Year the lab manager will retire. During this next year, the division will send high complexity laboratory testing to outside labs. This will leave wet mounts as the single laboratory test that requires a moderate complexity lab certificate.

3. Public Health Promotion includes activities and programs designed to address specific health risks and to promote policies, systems and environments that promote health.

    a. Continued budget cuts to the Public Health Division have significantly reduced our capacity to conduct population based public health initiatives to advance policies, systems and environments that promote health and prevent disease. Community assessment and engagement efforts—essential elements of public health practice--are limited to the implementation of the Tobacco Prevention and Education grant program activities. In July 2010, Douglas County received a one-year Healthy Communities capacity building grant to conduct identified barriers to health and possible solutions. Funding for implementation of the Healthy Communities project is not anticipated for FY 11/12. Sustainability efforts for this project have included two ACHIEVE grant application and broad-based community outreach to build and strengthen partnerships to support ongoing efforts, e.g., coordination of chronic disease self-management

programs and services.

b. Over the past few years, budget reductions have eliminated Douglas County's child passenger safety seat education and distribution program; senior health education; physical activity and nutrition activities; oral health promotion (except as related to the Baby Smiles Project); child injury prevention (excepts as related to Maternity Case Managements and Babies First); and many activities related to community health assessment, capacity building, and community mobilization.

c. Basic client-based health education continues to be provided to individuals/families who receive services through various Public Health Division programs (e.g., Nurse Home Visit, WIC, and Family Planning).

4. Epidemiological investigation of deaths of public health significance with the county's medical examiner's office:

   a. The medical examiner notifies the Public Health Division of deaths of public health significance.

5. Nutrition services including identification and intervention with client's at nutritional risk, and education and consultation for the promotion of good dietary habits:

   a. Nutrition services are provided by the WIC Program. Nutritional assessment and education pieces are included within Maternity Case Management, Babies First!, Tuberculosis Program, HIV Case Management, CaCoon, Family Planning, and other Public Health programs.

The following areas listed in OAR 333-014-0050 will not be supported with staffing, planning, or resources in fiscal year 2011-2012: community-based dental health (except as related to the Baby Smiles research project), health education/health promotion (except as it relates to tobacco prevention), older adult health education, and primary health care services.

III. ACTION PLAN

Action plans are included for:

1. Epidemiology and Control of Communicable Diseases
2. Emergency Preparedness
3. HIV
4. STD
5. Tuberculosis
6. West Nile Virus
7. WIC
8. Family Planning
9. Perinatal Health
10. Child Health
11. Adolescent Health
12. Immunizations
13. Oral Health
14. Nutrition and Physical Activity
15. Substance Abuse
16. Child Injury Prevention
17. Health statistics
18. Health information and referral services
19. Environmental health
20. Water

III.1 Action Plan: Epidemiology & Control of Preventable Diseases

a. Current condition

DCHSS is mandated by Oregon law to "use all reasonable means to investigate in a timely manner all reports of reportable diseases, infections, or conditions" (OAR 333-019-0000). With regard to public health emergency preparedness, Douglas County has taken steps to ensure timely detection, response, and efficiency in communicable disease reporting. State Support for Public Health dollars were doubled in 2007-2008, which awarded Douglas County $121,000 versus the previous award of $60,600. However, in fiscal year 2010-2011 Douglas County was awarded $122, 264, a figure based on County population and not increased for inflation or the downturn in economy. The increased State Support for Public Health dollars is not even sufficient to fund two nurses and because local public health relies on state funding streams that have remained static over the years, or have even decreased or disappeared, the State Support for Public Health dollars have been spread to HIV, STD, TB, Communicable Disease, and Environmental Health programs in order to preserve public health functions. A separate funding stream, the federal funds for public health preparedness which started after September 11th, has helped our department to respond to communicable disease outbreaks, as well as support critical emergency response planning; however, these funds have also been decreasing, and for the first time, in 2009, the Public Health Division in the Health Department did not receive a portion of this emergency response funding. A separate funding stream, the federal funds for response to the 2009-2010 H1N1 outbreak, has helped our department's critical response to pandemic influenza; however, these funds are difficult to put to use when budget cuts in basic local Public Health programs are occurring at the same time.

It is difficult to sustain a minimally adequate response to epidemiology and control of preventable diseases when State funding has been reduced or is unpredictable, and County Public Health Programs rely on grant funding and County general fund dollars. In our current staffing situation, there are little to no resources to offer community education opportunities e.g. health fairs.

In 2010, DCHSS investigated 386 cases of reportable diseases (excludes HIV/STD/TB cases and reportable influenza cases), compared to 280 cases in 2009. In addition, communicable disease control includes investigations of clusters or outbreaks of reportable diseases. In 2010, Douglas County investigated 8 outbreaks, most notably a restaurant associated Salmonella outbreak with 73 cases; a multi-county Salmonella outbreak associated with a local pasteurized milk distribution facility with 23 cases and a product recall; a multi-state raw cheese E. coli outbreak with product recall, an increased incidence of Meningococcal serotype C with 6 cases, and the 2009-2010 H1N1 Influenza Outbreak.

Douglas County has membership on the CHLO-Epi Committee. Although meetings are held in Salem, DCHSS staff attends by phone due to budget cuts. In 2009, Douglas County

became one of two counties to pilot and assist in the development of the new Oregon Public Health Epidemiology User System (Orpheus), a statewide communicable disease reporting database that now nearly the entire state of Oregon has transitioned to. Orpheus has greatly improved the timeliness of communicable disease case reporting to DHS.

Hepatitis C virus (HCV) is the most frequently reported communicable disease, other than Chlamydia. In 2010, Douglas County had 216 cases of chronic HCV reported. In 2010, Douglas County had 5 cases of acute HCV reported out of the 21 cases reported in Oregon. DCHSS mails information to each newly reported adult confirmed case of HCV to recommend Hepatitis A and Hepatitis B vaccination at low-cost through 317 Immunization funding. DCHSS partners with the local community based organization, Harm Reduction Center of Southern Oregon (HRCSO), to screen high risk persons for HCV. In 2007, DCHSS assisted HRCSO to begin using the Home Access HCV screening kit to screen high risk individuals, including needle exchange clients. In 2006-2010, DCHSS participated in a free HCV screening project with DHS that targets high risk persons and collected epidemiological information about risk behaviors. Due to budget cuts and staff turnover at HRCSO, DCHSS has had limited involvement in HCV screening outreach in 2009 or 2010.

In year 2010, due to staffing cuts, DCHSS restructured the Communicable Disease Clinic services and merged them with Immunization and STD/HIV services. Therefore, now there is not a separate Communicable Disease clinic for TB refills, adult immunizations, post-vaccine screens, Hepatitis C screening, and head lice and scabies evaluations. This Communicable Disease Clinic previously in 2008 served 101 unduplicated clients in direct clinic services in Roseburg and satellite communicable disease clinics. DCHSS no longer provides head lice and scabies evaluations.

b. **Goals**

a. To identify, prevent, & decrease endemic and emerging communicable and environmentally related diseases in Douglas County
b. To target & vaccinate high-risk populations against vaccine-preventable diseases
c. To improve public health preparedness
d. To educate the public regarding communicable disease prevention, and
e. To maintain and improve communicable disease reporting practices by local health care providers and laboratories
f. To provide the ability to receive and respond to communicable disease reports and public health emergencies 24/7

c. **Activities**

Target population: Douglas County

a. Provide epidemiologic investigations to report, monitor, and control communicable disease and other health hazards

b. Provide diagnostic and consultative communicable diseases services
c. Assure early detection, education, and prevention activities to reduce the morbidity and mortality of reportable communicable disease, e.g., E-Sentinel, ELR
d. Assure the availability of immunizations for human and animal target populations; target and vaccinate high-risk human populations specifically through special projects aimed at STD, HIV, and HCV populations
e. Collect and analyze communicable disease and other health hazard data for program planning and management to assure the health of the public
f. Train all public health nurses in communicable disease control, including fit testing of identified staff
g. Maintain Health Alert Network broadcast fax/email system
h. Continue public health preparedness exercises and planning
i. Continue discussions with local health care providers and local and reference laboratories regarding timeliness and accuracy of reporting communicable diseases
j. Continue limited communicable disease education in community settings, e.g., senior centers, doctor offices, health fairs, and among community partners and emergency responders
k. Continue to work with State to implement the Oregon Public Health Epi User System (Orpheus) in disease reporting
l. Continue limited community collaboration for prevention of Hepatitis C
m. Continue CHLO-Epi membership
n. Programmatic stability with current budget forecast

d. **Evaluation**

a. Number of 12 day intervals between receipt of case reports at County and receipt of case reports at State, as described in the monthly communicable disease surveillance report as a marker for timely reporting from the local to state level
b. Number of days between receipt of case reports at the County and receipt of case reports at the State, as described in the monthly communicable disease surveillance report as a marker for timely reporting from the local to state level
c. Number of elements missing in Orpheus, specifically completed outcome status
d. Timeliness of turning in outbreak summary reports to State within 30 days after last onset of disease plus seven days
e. Meeting the Conference of Local Health Officials Minimum Standards for reportable Communicable Disease Control, Investigation and Prevention
f. Results of internal Continuous Quality Improvement reviews
g. Vaccine preventable diseases will decline
h. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

III.2 Action Plan: Emergency Preparedness

a. Current condition:

After the completion of the 2009 H1N1 Pandemic Flu events, CDC granted a one year extension of the 5 year Preparedness Grant. State and local health departments were to use this opportunity to review their plans and infrastructure and spend their efforts implementing improvements identified in their after action reports.

Three large earthquakes happened on the Ring of Fire. In Japan, 9.0 earthquake produced a tsunami that did damage to several coastal communities. The Reedsport area of Douglas County was fortunate to receive almost no damage from the tsunami. The Community did respond and evacuated one senior center and activated the opening of a shelter until the tsunami threat was canceled. The Douglas County EOC IC decided not to alert Public Health when the EOC was activated. Douglas County Health had very few inquiries to the radiation discharge from the Fukushima Daiichi power plant. As information was provided from the federal and state level, this information was made available on the Public Health website.

On March 31, 2011, a 71 mph wind storm that lasted less than thirty minutes and caused multiple power failures, downed trees, damaged houses and business throughout Douglas County. Fortunately no one was seriously injured. Douglas County has and will again be affected by major storms, wildfires, floods, and has the potential to be devastated by major earthquakes, tsunamis or pandemic flu. These disasters increase awareness of the need of all hazards planning and preparedness in the nation and the world. DCHSS must be prepared to identify and respond to bioterrorism as well as natural disasters, outbreaks of infectious diseases, and other threats to protect the health of our community. Improvements in public health preparedness have increased the functional capacity of day-to-day operations of DCHSS. DCHSS staff continue to work and exercise with local and state partners to refine procedures for responding to a broad range of disasters and emergencies.

By June 30, 2011, Douglas County will have completed the assessment, planning and purchase of materials for a Federal Medical Facility/ Reedsport Emergency Medical Equipment Cache and backup health clinic. This project was possible through funds received through two mini preparedness grants and the Hospital Preparedness Program.

Some of the major preparedness projects for 2010 include the following:

- Acceptance of supervision for the Citizen Emergency Response Team, CERT, coordination of efforts and resources in emergency preparedness in Douglas County.
- CERT participation in the Fire Safety Fair
- Development and adoption of a Continuity of Operation Plan
- Development of an ESF 8 plan for the Douglas County Emergency Operation Plan
- Continued response to the 2009 H1N1 Pandemic Flu
- Assessment, planning and upgrade of infrastructure to support mass vaccinations

- Public Health and Environmental Health responded to two large Salmonella foodborne outbreaks, along with several GI illness outbreaks associated with events at local wineries. An After Action Report was written for the first outbreak.
- Public Health used the Isolation and Quarantine statues and administrative rules to address an uncooperative tuberculosis patient.
- The department has implemented a monthly First Aid/CPR/AED training for health department employees with the goal to have all employees trained in First Aid/CPR/AED.
- Assisted in the drafting of the U-Trans Security and Emergency Plan
- DCHSS staff participated in one table top and one functional exercise
- DCHSS continues to support ICS training requirements as listed in staff job descriptions, this has been in effect since 2006.
- Douglas County staff participated in evaluating exercises at the Roseburg Veterans Administration Hospital and Bay Area Hospital. Written reports were completed for these exercises.
- Attended the EOC Incident Management Team Integration training at EMI.
- CERT Manager attended the CERT Manager and Train the Trainer classes at EMI

b. Goals:

a. To survive a disaster, this is likely to be a Cascadia subduction zone earthquake. Then be one of the first ready to receive and use the resources that will come.
b. Continue to improve the medical cache in Reedsport.
c. Increase the number of CERT train citizens by offering more classes per year.
d. To enhance epidemiological surge capacity to respond to biological threats and disease outbreaks
e. To continue the dissemination of accurate and timely information to the public, doctors, emergency responders, hospitals and other community partners through the Health Alert Network
f. To integrate all hazards preparedness plans and procedures into the Douglas County Emergency Operations Plan

c. Activities:

a. Using the new CDC proposed capability goals development and refinement Douglas County Health & Social Services emergency response capabilities for Strategic National Stockpile distribution, Mass Prophylaxis Plan, Chemical, Radiation, Health and Medical Annex, and All Hazards Plan
b. Maintain and enhance the emergency medical caches
c. Continue to offer department staff communicable disease training to augment surge capacity abilities, NIMS, and risk communication skills
d. Continue participation in the CLHO-Epi Committee, Region 3 Healthcare Resources Services Administration Board, CHLO Public Health

Preparedness Leadership Team, Emergency Management Advisory Group, and Public Information Officer Network

e. Test and train on the county Health Alert Network system and Alert Oregon.
f. Continue 24/7 staff response to public health emergencies
g. Use ICS when dealing with large scale events
h. Continue to plan and/or participate in public health preparedness training and exercises at the local, regional and state levels
i. Continue public education campaigns about emerging diseases, e.g., West Nile Virus, Pandemic Influenza as needed
j. Continue to meet with the Cow Creek Tribe for the development of a tribe emergency plan and a Mutual Aid Agreement
k. Begin to incorporate special population organizations into emergency preparedness plans
l. Continue to acquire and utilize the appropriate computer equipment, radios and wireless technology that meet the interoperable communications requirements of the County, State and Federal governments
m. Assist U-Trans with the development and testing of their transportation security and emergency response plan
n. Cooperate with Mercy Medical Center in developing their hospital evacuation plan
o. Participate in the Douglas County Disaster Recovery program.

d. Evaluation:

a. Review and update existing plans as needed and identified during exercises.
b. Revise and update the Douglas County Health and Medical Annex E
c. Documentation of DCHSS responder participation in state and local emergency management planning and training activities
d. Documentation of health department staff participation in NIMS, public health and bioterrorism education
e. Documentation of the transmission of CDC HAN alerts and advisories to healthcare providers, hospitals and emergency responders
f. Compliance with the annual PE 12 Program Review conducted by the Oregon Department of Human Services
g. Meet or exceed the contract requirements in the CERT grant.

III.3 Action Plan: HIV

a. Current condition

By Oregon law, physicians and laboratories are required to report HIV infection to the health department. Disease reporting enables public health follow-up, identify outbreaks, provides a better understanding of disease patterns, and may even save lives. This includes the following components: (i) investigations that report, monitor, and control diseases, (ii) lab testing and consultation, (iii) early detection, education, and prevention activities to reduce the disease and death rates of reportable communicable diseases, and (iv) collection and analysis of data for program planning. In 2010, DCHSS investigated 1 newly reported HIV case in collaboration with the state HIV Disease Intervention Specialist.

In fiscal year 2010-2011 Douglas County contracted with the Harm Reduction Center of Southern Oregon (HRCSO) to provide HIV Counseling and Testing (CTRS), Outreach to CTRS, Harm Reduction services, Social Networking Strategy, and Ryan White CARE Act services. DCHSS staff provides ongoing technical assistance to the HRCSO. There has been an increased need for technical assistance and monitoring of HRCSO in 2009-2011 due to new staff in nearly all positions at HRCSO, including directorship.

HIV Testing, Counseling, and Referral services are offered at the Roseburg health department site by appointment. Services are also subcontracted to the HRCSO who provides HIV Testing, Counseling, and Referral. Both programs offer Anonymous or Confidential testing. From 2010, DCHSS administered 163 HIV tests and HRCSO administered 259 HIV tests. Every year since 2008, fewer tests have been done at both sites annually, likely due to staffing turnover and reductions at both facilities. Of these tests done by DCHSS and HRCSO in 2010, 56% of the HIV tests were to the high risk populations of Men who have Sex with Men (MSM), IV Drug Users (IDU), MSM/IDU, or sex or needle partner is HIV positive. Both programs utilize Rapid HIV testing.

Outreach services are subcontracted to HRCSO. Services include the extending of HIV prevention services or activities beyond current or usual limits. The activities are targeted at high risk populations and meeting those populations where they are at, not waiting for someone to walk into HRCSO or DCHSS.

Harm Reduction services are subcontracted to HRCSO. Services include education about harm reduction and prevention of HIV and other blood borne infections. HRCSO does community presentations, most recent at Job Corps, ADAPT, Corrections, Confidence Clinic, Samaritan Inn, and Casa de Belen. Harm Reduction services include a syringe exchange program where in for example November 2010, 5900 syringes were turned in and 7400 syringes were given out. DCHSS and HRCSO both have drop-boxes for citizens to put sharps and syringes in 24 hours a day, 7 days a week. A syringe exchange program keeps syringes

off streets, out of landfills, and prevents disease transmission. DCHSS and HRCSO participate in a project that targets persons with risk factors for HCV acquisition with free screening. The highest risk for HCV transmission is IV Drug Use, even if only one time injecting.

Social Network Strategy (SNS) services are subcontracted to HRCSO. SNS is an intervention in which high risk persons are recruited to bring in their high risk associates for HIV testing. The recruiters and the associates receive financial incentive. Recruiters are either HIV/AIDS positive or are MSM who participate in high risk activities. In 2011, Douglas County became the first county to pilot and assist in the development of the new Social HIV Electronic Record (sHIVer), a statewide database for implementation of the SNS Program.

HRCSO and DCHSS coordinate the Ryan White Title II Case Management services for HIV positive persons. The health department provides Nursing Case Management 4 hours a week. The Nurse Case Manager and HRCSO's Psychosocial Case Manager assist clients in accessing HIV medical care, thus reducing viral load and preventing HIV transmission. They also assist clients in accessing support services that include medical emergency financial assistance, psychosocial emergency financial assistance, housing services, linguistic services, medical transportation services, and oral health care. They also assist clients in accessing State Managed Services which include dental services; mental health, substance abuse treatment, home health and medical nutritional services. In 2010, there were an estimated 67 HIV positive persons living in Douglas County. The Ryan White Case Management program served 36 HIV positive persons during 2010 and the caseload in 2011 currently has 21 persons enrolled. Although MSM is the largest risk factor for HIV, 38% of the Douglas County Ryan White caseload is female.

Douglas County has membership on the CHLO-HIV Committee. Although meetings are held in Portland, DCHSS staff attends by phone due to budget cuts. In 2010, Douglas County had membership on a funding formula subcommittee and also membership on a state workgroup which modified the Harm Reduction and Outreach forms.

In 2009-2010, the DCHSS integrated STD and HIV Programs were budgeted for 1.66 FTE, in 2010-2011 for 0.96 FTE, and as we approach 2011-2012 the budget will be reduced to 0.81 FTE. With less funding and less staffing means a lesser ability to do as many high risk HIV tests as in past years. In addition, with the Governor's proposed budget cuts for 2011-2013, DCHSS is poised to enter fiscal year 2011-2012 with a state contract in the amount of $30, 425; this is $11,149 less than the previous year. In addition, there is an expected change in the HIV funding formula that determines the financial award and therefore, in 2012-2013 DCHSS is expected to receive $24,272. DCHSS's capacity to prevent HIV infection has been and will be greatly reduced.

The Douglas County and HRCSO HIV Prevention Program Plan are available on request that further outline goals and activities for 2011-2012.

b. Goals

a. To prevent the further spread of HIV infection in Douglas County
b. To reduce AIDS and HIV case rates in Douglas County
c. To provide support services to Persons Living with HIV or AIDS (PLWHA)
d. To target and vaccinate high-risk populations against vaccine-preventable diseases
e. To reduce barriers to HIV testing and counseling
f. Continue use of rapid HIV testing
g. Programmatic stability with current budget forecast
h. To investigate cases of new HIV infection

c. Activities

Target population: PLWHA, Men who have sex with men, IV drug users, Hepatitis C population, persons at risk for HIV and other blood borne pathogens

a. HIV Counseling and Testing to high risk populations
b. Conduct HIV disease investigation with newly reported positive HIV cases
c. Integrate STD, HIV, and Hepatitis C prevention efforts
d. Target and vaccinate high-risk populations against vaccine preventable diseases
e. Limited communicable disease education in community settings, e.g., medical providers, health fairs, community agencies, and venues with target populations
f. Case management of HIV and AIDS cases at HRCSO
g. Complete activities as outlined in the 2011-2012 HIV Prevention Planning documents; HIV CTRS, HIV OHROCS, HIV Social Network Strategy, etc
h. Support HRCSO ongoing efforts, e.g., complete quality assurance for RWCA case management program, coordinate joint Hepatitis C efforts when able
i. Continue to work with State to implement the Oregon Public Health Epi User System (Orpheus) in disease reporting

d. Evaluation

a. Number of HIV tests done at DCHSS and HRCSO, specifically Partners of PLWHA, MSM, MSM/IDU, and IDU populations
b. Return rate for HIV results at DCHSS and HRCSO
c. Number of condoms distributed at DCHSS and HRCSO
d. Number of syringes exchanged at HRCSO
e. Number of Hepatitis B and C testing done at DCHSS to high risk populations
f. HIV and AIDS rates in Douglas County
g. Number of Hepatitis A and B immunizations to high risk populations
h. Number of PLWHA receiving case management services
i. Number of MSM in Social Network Strategy that learn their HIV status for first time
j. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

III.4 Action Plan: Sexually Transmitted Disease (STD)

a. Current condition

Douglas County, as described in Divisions 17, 18 and 19 of OAR Chapter 333, bears the primary responsibility for identifying potential outbreaks of Sexually Transmitted Diseases (STDs), for preventing the incidence of STDs, and for reporting in a timely manner the incidence of Reportable STDs to the appropriate Department authorities. In addition, under contract with DHS, Douglas County may not deny STD clinical services to an individual seeking such services; must use all reasonable means to investigate in a timely manner all reports it receives of Reportable STDs in order to identify possible sources of infection and to carry out appropriate control measures; must offer STD cases and contacts, reported to or identified by DCHSS, evaluation and treatment; must provide staff time to examine, diagnose, and treat all individuals seeking examination, diagnosis or treatment for a Reportable STD; and must also perform, as resources permit, STD contact interview and partner notification services to individuals with Reportable STDs diagnosed by or reported to DCHSS. While resources may be limited it is expected that DCHSS will provide services to at least 20% of the individuals with Reportable STDs diagnosed by or reported to DCHSS.

DCHSS provides STD clinical services in the Roseburg office and also provides STD Case Management. In 2009-2010, the DCHSS integrated STD and HIV Programs were budgeted for 1.66 FTE, in 2010-2011 for 0.96 FTE, and as we approach 2011-2012 the budget will be reduced to 0.81 FTE. With less funding and less staffing means a lesser ability to do STD screening and case management as in past years. In 2009, STD/HIV clinic services were available four days a week. With budget cuts in 2010, clinic services were available by appointment three or fewer days a week. With less staffing, responsibilities for STD Case Management have been added to other staff's existing workloads.

DCHSS receives no state funding dollars to operate a STD Program. Douglas County does receive from the state 'In-Kind Resources' of antibiotics for treating STDs and receives at request Technical Assistance Resources of a Disease Intervention Specialist that is assigned to our region. As of March 2010, universal Chlamydia screening is no longer available in Public Health clinics due to state budget cuts; screening has been restricted to those at highest risk and those with Oregon Health Plan or CCARE coverage, otherwise costs are passed on to the client or screening not done.

Chlamydia is the most frequently reported STD. Douglas County reported 257 cases of Chlamydia, 4 cases of Gonorrhea, and 1 case of Syphilis in 2010. In comparison, Douglas County reported 186 cases of Chlamydia in 2009. In 2010, DCHSS diagnosed 115 cases (44% of the reported Chlamydia cases) in Douglas County through the DCHSS clinics. In 2010, DCHSS served 684 unduplicated clients with office visits in the STD and HIV Programs with a total of 807 clinic visits. In 2010, DCHSS provided 1536 tests for Chlamydia & Gonorrhea and 168 tests for Syphilis. In 2010, the STD clinic had a 13% positivity rate for the Chlamydia

tests the clinic ordered. In 2010, the Adult Health clinic had a 3.8% positivity rate for Chlamydia tests the clinic ordered.

b. Goals

a. Prevent or minimize neonatal morbidity due to reportable bacterial STIs and conditions, including pelvic inflammatory disease and lymphogranuloma venereum
b. Preserve fertility
c. Diminish or prevent catastrophic consequences, such as stillbirths, congenital syphilis, miscarriages, chronic infection, and chronic pelvic pain due to STDs
d. Reduce the prevalence of STDs
e. Address STIs, including reportable, acute and chronic viral infections such as hepatitis A, B, and C, and HIV; and non-reportable chronic viral infections such as HPV, and HSV, as resources permit
f. Reduce the reproductive number of an STD. Reducing the reproductive number of an STD requires at least one of the following occurs: 1) Shorten the average duration of infection. Methods include: early diagnosis and treatment, case investigation, follow-up and partner services, 2) Reduce the average probability of transmission per partner sexual contact. Methods include: condom use, fewer sex acts, and/or 3) Decrease the average number of sexual partners per unit of time. Methods include changing individual and community norms; encourage monogamy and serial monogamy; decrease number of concurrent partners
g. Over 3% Chlamydia positivity in DCHSS clinics demonstrates effective screening
h. Programmatic stability with current budget forecast

c. Activities

a. Ensure a system for STD surveillance
b. Ensure the evaluation and treatment of individuals with reportable, bacterial STDs, including PID (STD eval/treatment)
c. Ensure that others at risk for infection (sex partners, associates, suspects, and clusters) are identified and offered evaluation and treatment (partner services)
d. Continue to work with State to implement the Oregon Public Health Epi User System (Orpheus) in disease reporting

d. Evaluation

a. Chlamydia rates in Douglas County
b. Gonorrhea rates in Douglas County
c. Early syphilis rates in Douglas County
d. Percent positivity of Chlamydia in DCHSS clinics
e. STD clinic appointment show rates
f. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

III.5 Action Plan: Tuberculosis

a. Current condition

By Oregon law, physicians and laboratories are required to report Tuberculosis disease to the health department. Disease reporting enables appropriate public health follow-up, helps identify outbreaks, provides a better understanding of disease patterns, and may even save lives. Services include: investigating and monitoring treatment for each case and suspected case of active TB disease, ensuring adequate TB treatment, requiring appropriate medical examinations and laboratory testing to confirm the diagnosis of TB and response to therapy, coordinating care as needed, providing medication for the treatment of TB, monitoring and ensuring adherence to treatment guidelines, monitoring medication side effects, monitoring clinical response to treatment, performing contact investigations and following infected contacts through completion of treatment, identifying barriers to care and implementing strategies to remove those barriers. The TB services also include participation in quarterly cohort review, acceptance of Class B waivers and interjurisdictional transfers for evaluation and follow-up, and screening and management of Latent TB Infection.

Douglas County received $3,506 in state funding dollars to operate a TB Program in fiscal year 2010-2011. Tuberculosis rates for the population of Douglas County remain stable with a low incidence rate. In 2010, the case rate was 1.9 diagnosed active TB cases reported to Douglas County per 100,000 population, while Oregon overall reported 2.3 cases per 100,000 population. In 2010, there were seven suspect cases of TB that took substantial staff time to case manage until the time that active TB was ruled out, one of which lived over an hour outside of Roseburg and required home visits as did not have a personal phone. In 2010, DCHSS spent 382 staff hours on Active TB Case Management. As of 03/12/2011, DCHSS has already spent 114 staff hours on Active TB Case Management due to time involving court ordered isolation of a TB case.

DCHSS does Directly Observed Therapy (DOT) which involves providing TB drugs to the patient and watching as the patient swallows the medications over the entire course of treatment, which can be an approximate six to twelve months of treatment. Although a standard of care, the use of DOT places a financial burden on local health department resources. Douglas County has utilized video conferencing DOT to save staff time and travel resources when appropriate. Nursing staff complete annual fit testing for N95 masks as required.

The LPHA provides medications for persons diagnosed with latent TB, where the TB germ is dormant in the body, who cannot afford to pay for TB medications. In 2010, the LPHA provided medications for one person with latent TB. The LPHA referred persons with latent TB that had insurance, or had the ability to pay, to their primary care provider for assessment and medications. In January 2010, Douglas County reorganized several clinics so treatment and monitoring for LTBI is now by appointment through either the nurse that

staffs the STD/HIV clinic appointments or through a Public Health Nurse that learns of a positive PPD needing evaluation through Immunization or Communicable Disease services. Bi-weekly walk-in services for medications refills are no longer available.

Services provided include PPD screening. These services are available in the Roseburg clinic where persons have the ability to return in 48 to 72 hours or as part of a TB contact investigation. In 2010, the LPHA administered and read 383 PPDs.

b. Goals

a. To have early and accurate detection, diagnosis, and reporting of TB cases leading to initiation and completion of treatment
b. To provide comprehensive case management to active TB cases, including Directly Observed Therapy
c. To identify contacts of patients with infectious TB and treat those at risk with an effective drug regimen.
d. Prevent transmission of TB
e. Maintain or meet the National TB Priority Indicators and Program Objectives
    1. For patients with newly diagnosed TB for whom 12 months or less of treatment is indicated, 93.0% will complete treatment within 12 months.
    2. For TB patients with positive acid-fast bacillus (AFB) sputum-smear results, 100.0% (of patients) will be elicited for contacts.
    3. For contacts of sputum AFB smear-positive TB cases, 93.0% will be evaluated for infection and disease.
    4. For contacts of sputum AFB smear-positive TB cases with newly diagnosed latent TB infection (LTBI), 88.0% will start treatment.
    5. For contacts of sputum AFB smear-positive TB cases that have started treatment for newly diagnosed LTBI, 79.0% will complete treatment.
    6. For TB cases in patients ages 12 years or older with a pleural or respiratory site of disease, 95% will have a sputum culture result reported.
f. To educate the health care providers and general public regarding tuberculosis
g. As needed, to identify settings in which a high risk exists for transmission of Mycobacterium tuberculosis and apply effective infection-control measures
h. Programmatic stability with current budget forecast

c. Activities

Target population: Active Tuberculosis cases first priority, close contacts of Active Tuberculosis cases second priority, LTBI infection third priority

a. Assess the extent and characteristics of TB in the jurisdiction through collection and analysis of epidemiologic data
b. Develop policies and procedures and a plan for controlling TB

c. Assure diagnostic, clinical, and preventive services needed to implement the plan for controlling TB
d. Provide information and education to policy makers, health-care professionals, and the public regarding control of TB in the jurisdiction
e. Train public health staff in communicable disease control, including N95 fit testing of identified staff
f. Offer Tuberculosis medication refills, and monitoring for side effects for eligible clients
g. Continue to work with State to implement the Oregon Public Health Epi User System (Orpheus) in disease reporting

d. Evaluation

a. Staff will report increased knowledge of tuberculosis and tuberculosis case management.
b. The tuberculosis case rate will remain stable or decrease in Douglas County
c. Evaluation of the National TB Priority Indicators and Program Objectives on the Douglas County and Oregon levels
d. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

III.6 Action Plan: Environmental Health

a. Current condition

Environmental factors have a great impact on the health of the community and quality of life. DCHSS works to establish and maintain a broad based approach to environmental health service delivery. Efforts are focused upon the influence and impact of environmental factors, both natural and manmade, and the management and control of these factors so as to prevent and control illnesses, in order to promote health. Local environmental health services are required by ORS 431.416 with specific standards performed or programs availability assured as authorized by OAR Chapter 333-014-00050. Services in Environmental Health include state-mandated health inspections, licensing & plan review of restaurants, public pools & tourist facilities, certification of food handlers, food borne illness disease investigations, oversight of public drinking water systems, West Nile Virus surveillance and education, environmental health education, disaster response, and animal bite investigations. In fiscal year 2009-2010, 1,241 inspections were conducted at the various licensed facilities and institutions, with 4,320 violations noted. The general public reported 30 complaints, with 10 reporting a food-borne illness but all failed to meet case definition requirements, and 1 food-borne illness outbreak investigations were done.

In 2010 a re-evaluation of the Environmental Health fee structure was made. The program was found to be underfunded by approximately $122,000. This is up by $37,000 from last year. The fee structure will be re-evaluated again in 2011.

The Douglas County Public Works Department manages and operates an effective solid waste disposal and recycling program. At the twelve free-of-charge county transfer sites and one central landfill, the environment is protected and public health hazard's reduced or eliminated. Private solid waste franchises provide adequate collection and disposal services. In the face of reduced County General Funding, the discussions are still taking place about imposing a fee structure for businesses or for citizens utilizing the landfill.

The Environmental Health Program participates on the Douglas County Solid Waste Advisory Committee.

The County Planning Department has taken over all program responsibilities of on-site wastewater management.

The Department of Agriculture performs all program responsibilities of shellfish sanitation. The Environmental Health Program collaborates with the Department of Agriculture when a recreational shellfish harvest closure is considered, when "Red Tide", "Domoic Acid", or sewage contamination affects shellfish digging areas. Through the food facility inspection program, restaurants that serve shellfish are monitored to assure shellfish products are from licensed and approved sources. The required identification tags are to be collected and maintained by the food facility.

a. Goals

The Environmental Health Program shall be vigilant in its continuous and ongoing efforts to reduce or eliminate environmental health risk factors that have the capacity to cause human suffering, disease, or injuries.

b. Activities

Target population: Douglas County

a. Inspection, licensure, consultation and complaint investigation of food services, tourist facilities, institutions, public spas and swimming pools, drinking water systems, to assure conformance with public health standards
b. Environmental Health assessment and planning
c. Food handler training is now offered on-line and in a classroom to all food service workers. The instruction provides food service workers with current methods of storing, preparing, and serving food to the public.
d. Information and referral services to the public and governmental agencies.
e. Investigation of community health hazards, reported animal bites, and diseases that potentially are relate to food or water or environmental causes
f. Liaison with local emergency response planning agencies, oversight of Bioterrorism, Chemical, Radiation, and Health & Medical annexes of the County Disaster Response Plan
g. Conduct West Nile Virus surveillance and provide public education
h. Lead poisoning investigation and counseling

c. Evaluation

a. The number of violations identified in food service establishments.
b. Review state wide trends associated with environmental diseases and compare them to what is happening in Douglas County.
c. Track trends in violations.
d. The number of complaints received concerning licenses facilities.
e. The number of Food borne Illness (FBI) complaints received.
f. The number of FBI outbreaks reported and investigated.
g. Maintain inspection frequencies of at least 90% in the number of food service facilities, tourist facilities, school and public facilities food service operations, public spas and pools, shelters and correctional facilities.
h. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services.
i. Monitor reported animal bites and resolutions

III. Action Plan: Safe Water

a. Current condition

Every community is faced with the threat that domestic water supplies may become contaminated and gives rise to communicable disease transmission and/or objectionable taste or odor problems. Should the improper disposal or spill of hazardous materials occur in surface waters, associated drinking water supplies would become at risk. Inadequate drinking water systems and/or substandard waste water treatment are factors which potentate the transmission of water-borne illnesses. Annually, approximately 18 public water systems are surveyed on site to assure proper construction and operation. Water lab test results, required to be completed routinely by the water system operator, are monitored for levels of chemical contaminants and any existence of indicator microorganisms.

b. Goals

a. To advise the general public of water-borne contaminants that may produce health risks from drinking, irrigating, swimming or wading
b. To follow-up on all disease outbreaks and emergencies including spills that occur in Douglas County
c. To complete all of the grant assurances including surveys, alerts, ERP reviews, and targeting system with more than 11 violation points.
d. 91% of the county population, served by public water systems, will receive water that meets all applicable health based drinking water standards throughout the year.

c. Activities

Target population: Douglas County

a. Provide technical and compliance assistance to all operators of public drinking water systems when these systems are found to be in violation of public health requirements and safe water quality standards
b. Investigate every incident of hazardous chemical spill or contamination; maintain membership in Oregon Emergency Response System (OERS)
c. Annual review and update of the Douglas County written plan for responding to emergencies that involve public water systems
d. Provide printed and verbal information regarding the development of safe water supplies to people using onsite water wells and springs as requested.
e. Disseminate advisories when high levels of e-coli or other bacteria or contact contaminants are discovered in naturally occurring rivers and streams.

d. Evaluation

a. Number of monitoring and reporting violations identified with public water systems.
b. Number of MCL monitoring violations identified of public water systems
c. Number of Public Water Systems with more than 11 violation points
d. All public water systems are provided with consultation and technical guidance when found in violation of safe water quality standards or who fail to monitor
e. At least 18 sanitary surveys completed annually
f. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

III.7 Action Plan: Women, Infant, Child (WIC)

See the attached 2011/2012 WIC Nutrition Education Plan, WIC Staff Training Plan, and Evaluation of 10/11 WIC Nutrition Education Plan.

III.8 Action Plan: Family Planning

a. Current Condition

The Douglas County Family Planning Clinic continues to offer contraceptive and reproductive health counseling, initial and annual reproductive health exams, screening tests and/or treatment for sexually transmitted diseases, and a variety of available birth control methods through the main Roseburg clinic and three outlying clinics. The clinics provide appointment visits as well as drop-in clinics. There are drop-in clinics for contraceptive counseling four days per week in Roseburg, and one day per week in the outlying offices. 93.9% of the clients are below 150% of the FPL with only 5.2% having third party insurance. Only 82.1% of the clients qualify for FPEP or OHP coverage. These health department services have resulted in averting 486 pregnancies, and serving over 2,480 (29.3%) women in need (DHS/ALHERS data, 2010).

With cuts that occurred in the 2010-2011 Public Health budget, another 0.5 FTE nursing position was eliminated. In the past, it has been difficult to recruit and hire nurse practitioner staff for the Family Planning Clinic. With decreased nursing capacity, we have decreased the availability of appointment times for initial, annual exams and drop in clinics for contraceptive management.

Information is provided to all clients about primary care providers and community health centers in the area to help meet those health care needs that are not provided in our clinic.

b. Goals

a. To improve and maintain the health status of women and men in Douglas County by providing reproductive health care services and to assure that all residents have access to voluntary and effective family planning methods.
b. Assure continued high quality clinical family planning and related preventive health services to improve overall individual and community health.
c. Reduce risk of unintended pregnancy.

c. Activities

Target population: Persons of reproductive age, especially of low-income, in Douglas County

a. Ensure adequate follow-up for abnormal pap smears through pap tracking system.
b. Ensure adequate screening for Chlamydia following the Region X infertility Prevention Project screening guidelines.
c. Evaluate monthly no-show rates by site.
d. Continue to conduct semi-annual client satisfaction surveys.

e. Continue to provide appropriate and available methods for birth control.
f. Maintain continuing education opportunities for professional and support staff activities.
g. Continue reproductive health exam, contraceptive counseling visits, and education in Roseburg and all outlying offices.

d. Evaluation

a. Review of AHLERS Data
b. Monthly chart audits
c. Review of data from internal IS system
d. Review of data service elements for group participations.
e. Review of data from internal system in tracking presentations.
f. Review AHLERS data for number pregnancies averted, percentage of women in need being served, and the number of teens being served.

III.9 Action Plan: Perinatal Health

a. Current condition

In July 2009 the Prenatal Care Clinic transition operations from a solely supported by the county to a cooperative support of DCIPA, UCHC, and Douglas County. This has resulted in the Prenatal Clinic Coordinator becoming an employee of DCIPA and maintaining the clinic at the county at a location that clients are familiar and feel safe in coming too. The Prenatal Clinic has provided prenatal care for 190 pregnant females a year in a community where the number of physicians providing prenatal care in Douglas County has decreased over the last several years; the Reedsport area of the county has no prenatal care provider.
The adequate prenatal care rate has continued to be stable in the 95% range. With the stabilization of the prenatal clinic funding it is noticed that the entry into first trimester care has improved to 85.6%. (HCCSO Data).

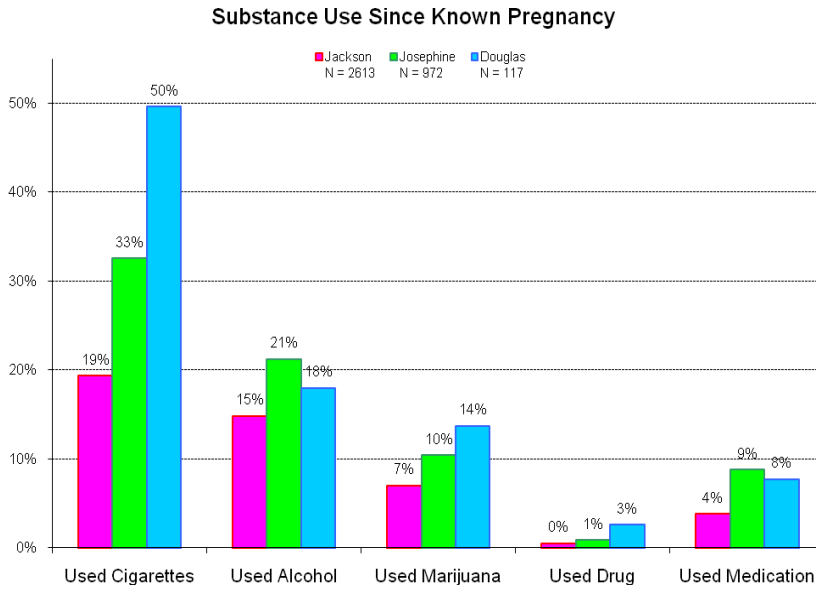
Douglas County currently has Public Health Nurses that provide Maternity Case Management (MCM) home visits to their assigned geographic area. The complexity of services needed has increased tremendously with the difficult issues of alcohol, drugs, mental health and violence. These continue to be ongoing challenges as we strive for healthy pregnancies. The MCM Program has implemented mandatory education concerning fetal alcohol, other drug and tobacco exposure, breastfeeding promotion, intimate partner violence, maternal/fetal HIV and Hepatitis B transmission, maternal oral health, nutrition/healthy weight/physical activity, perinatal mood disorders, and prematurity and pre-term birth risks.

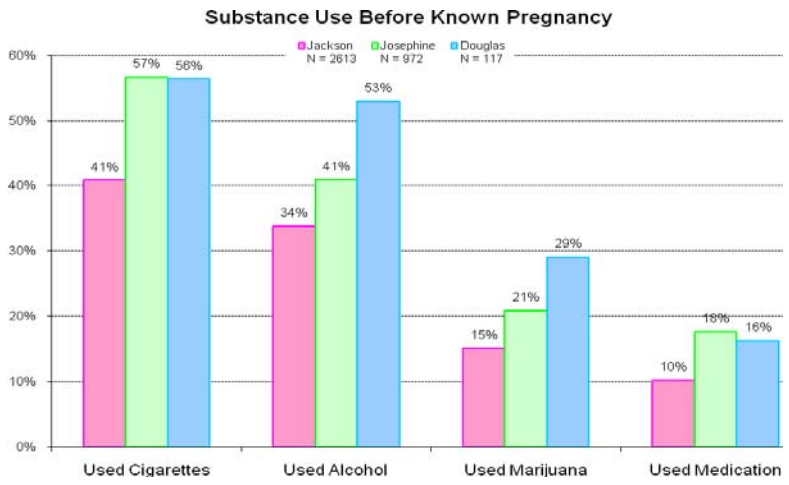
DCHSS has Public Health Nurses that provide Maternity Case Management home visits to their assigned geographic area. Two of these positions are funded through a federal grant for “Eliminating Disparities” and reducing infant mortality in targeted zip codes and the Hispanic population. As part of the federal grant, women are also being screened for maternal depression using the PHQ-9. Women are screened once prenatally and once postpartum. The next phase of the project will look to build linkages and partnerships between public health and mental health services. Alcohol, drugs, mental health and violence increase the complexity of needed services. These continue to be ongoing challenges as we strive for a healthy baby. 85.7% of the maternity case management caseload receive early prenatal care. (HCCSO Data).

At this time for fiscal year 2011-2012, we do expect a reduction in field nurse positions. Currently there are two vacancies and we anticipate a third by the end of the fiscal year. We anticipate not being able to fill at least one of these positions due to budget reductions. Recruitment is a challenge for these nursing positions due to lack of a competitive wage and lack of Bachelor Degree prepared nurses in the community. The reduction of a field nurse position not only means a struggle to meet Maternity Case Management program goals, but also means reduced capacity to meet clinic demands, e.g., Immunizations, STD, HIV, Family Planning, or Communicable Disease.

The Public Health Division is working in to reduce the rate of tobacco use among pregnant women by including tobacco use screening and counseling as part of all clinic and home visit encounters. Home visit nurses are trained to use the 5As -- a scientifically proven five-step smoking cessation counseling method to increase smoking cessation among the women they serve. In 2008, Douglas County Public Health received a $10,000 grant from the March of Dimes-Greater Oregon Chapter for a one year Baby & Me Tobacco-Free project to address maternal smoking in Douglas County. Although the original grant period has ended, we have continued the project through the Maternity Case Management and Prenatal Clinic programs. Data from the program show Baby & Me to be successful in helping women to quit smoking during pregnancy and to stay quit after the birth of their baby. We have enrolled 69 women in the program. The quit rate for participants in the program is about fifty percent.

In 2008, the Douglas County Perinatal Task Force was formed to address the problem of tobacco, drug, and alcohol use among pregnant women, lack of adequate prenatal care and to improve prenatal outcomes for the women of Douglas County. In April 2009, Douglas County Public Health began implementation of the SART system. The SART system consists of Screening, Assessing, Referring, and Treatment for pregnant and potentially pregnant women for drug and alcohol use. The SART system was developed by the Children's Research Triangle in Chicago, Illinois. Douglas County was chosen as one of the sites to implement this program. In June 2009, SART was expanded to include all of the area OBGYN practices. The goal is that all pregnant women in Douglas County will be universally screened for drug and alcohol use, and will receive appropriate referrals and treatment. Currently there are 3 of our 4 local OBGYN providers in addition to the Douglas County Prenatal Clinic that have been trained and are participating in screening women using the SART system.





Public Health is one of four counties (Douglas, Josephine, Lincoln, Jefferson) participating in the Baby Smiles Project to increase utilization of dental health benefits for Medicaid eligible pregnant women and to reduce early childhood dental caries. The project, which is being implemented by the University of Washington and Klamath County, is expected follow 102 pregnant during their pregnancy and 2 months post-partum. A .60 FTE Baby Smiles Coordinator has been hired to coordinate the project in Douglas County.

Douglas County has continued to participate in the Oregon Mothers Care Program. With the Public Health Division as an Oregon Mothers Care site, we hope to increase the number of women receiving first trimester prenatal care by being a liaison for them with OHP and other needed services during their pregnancy (e.g., WIC, prenatal care provider, home visiting services).

b. Goals

The Maternity Case Management Program provides an expansion of perinatal services to include management of health, social, economic, and nutritional factors. The purpose is to reduce the incidence of low birth weight infants and other poor pregnancy outcomes.

c. Activities

Target population: Pregnant women, especially of low-income, in Douglas County

a. Pre-conception counseling
b. Pregnancy and Parenting Education
c. Referral to Community Resources, e.g., WIC, Maternity Case Management, Family Planning
d. Continuation of Baby Smiles Oral Health Project
e. Continuation of Baby & Me Tobacco-Free

d. Evaluation

a. Percent of pregnant women who access prenatal care in their first trimester
b. Infant mortality rate per year
c. Infant low birth-weight rate per year
d. Percent of women who smoke during pregnancy
e. Number of pregnant women who agree to Maternity Case Management home visiting Program
f. Teen pregnancy rate per year
g. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services
h. Number of women who quit smoking during pregnancy and who stay quit at 3 and 6 months after the birth of their babies.
i. Successful participation in evaluation protocol of Baby Smiles Oral Health Project as determined by the University of Washington.

III.10 Action Plan: Child Health

a. Current condition

DCHSS has Public Health Nurses that provide Babies First! and Targeted Case Management home visits to their assigned geographic area. Two of these positions are funded through a federal grant for "Eliminating Disparities" and reducing infant mortality in targeted zip codes. Alcohol, drugs, mental health and violence increase the complexity of needed services. These continue to be ongoing challenges as we strive for a healthy baby. The Public Health Division participates in the Douglas County Multi-Disciplinary Child Abuse Team and the Douglas County Child Fatality Review Team. These teams work to decrease child abuse and mortality.

We do expect reduction in field nurse positions during FY 2011-2012. Currently there are 2 vacancies for field nurse positions and we anticipate a third by July 2011. As a result of budget reductions, we may lose one of these positions. There have been challenges in filling nurse vacancies due to our inability to offer a competitive wage. The reduction of a field nurse position not only means a struggle to meet Home Visit Program goals, but also means reduced capacity to meet clinic demands, e.g., Immunizations, STD, HIV, Family Planning, and Communicable Disease.

DCHSS provides a Public Health Nurse under contract with the local ESD to provide nurse delegation for special needs children within the school environment. This same nurse provides home care coordination for children with special health care needs through the state CaCoon program. A public health representative sits on the Early Intervention Council.

The local Commission on Children and Families and the Healthy Start Advisory Board made the decision to transition the Healthy Start Program to a private non-profit agency in October 2008. Douglas County Public Health continues to work collaboratively with the Healthy Start program to meet the complex health and social service needs of children and families. The Public Health Division Director is represented on the Douglas County Early Childhood Planning Coalition and the Healthy Start Advisory Board.

b. Goals

a. Improve the physical, developmental, and emotional health of high risk infants
b. Improve the early identification of infants and young children at risk of developmental delay and/or other health/medical related issues
c. Assist families to identify and access the appropriate community resources that meet their child's specific needs
d. Standardize a public health nurse's ability to: assess child development and health issues affecting young children, use screening tools appropriately, and make community resources available for referral
e. Health outcomes will be collected and analyzed yearly

f. Reduce child abuse and neglect rates
g. Reduce infant mortality
h. Improve the percent of 2-year-olds who are adequately immunized
i. Promote and improve the overall health status of parents and children in Douglas County through preventive health programs and services
j. Increase access to preventive and ongoing health care
k. Identify basic health and developmental needs in children throughout Douglas County from birth through age five
l. Increase children's school readiness by early identification of developmental milestones
m. Promote positive parent-child interactions, parent education and support, and referrals to community partners

c. Activities

Target population: High-risk infants and children, ages birth to four years in Douglas County

Key activities include outreach, home visits, health assessment and developmental screening, growth monitoring, case management, parenting education, information and referral, health education, and advocacy. All infants receiving home visits through the Babies First! Program will be screened and assessed based on the Babies First! Program manual. All children found to have abnormal screening will be referred for intervention. All families will be assessed for case management needs. All Public Health Nurses will receive Babies First! orientation and ongoing education in infant growth and development, child health issues, child medical concerns, and appropriate screening and assessment tools.

a. Education, screening and follow up, counseling, referral, or health services for family planning, perinatal care, infants, and children
b. Screening and physical exams that evaluate developmental achievements, growth parameters, immunization status, hearing & vision acuities, speech and language development, and provide ongoing education, information and referral
c. Provide and coordinate varied programs to meet parent and child needs in Douglas County; WIC Program, Immunization Clinic services, Family Planning services, Maternity Case Management, Targeted Case Management through the Babies First Program, and CaCoon Coordination
d. Continue participation in the Douglas County Multi-Disciplinary Child Abuse Team, Douglas County Early Childhood Planning Coalition, and Douglas County Child Fatality Review Team

d. Evaluation

a. Percent of all newborns in Oregon referred to the Babies First! program for screening, assessment, and follow-up

b. Percent of infants and children who experience normal growth and development patterns by 12 month screening
c. Percent of 2-year-olds who are adequately immunized
d. Percent of 2-year-olds who have normal dental screenings
e. Percent of 2-year-olds who demonstrate normal hearing and vision
f. Post-neonatal mortality rate per year
g. Child abuse and neglect rates per year
h. Low birth weight rate per year
i. Infant mortality rate per year
j. Percent of mothers breastfeeding at six months and at 12 months
k. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

III.11 Action Plan: Adolescent Health

a. Current condition

Due to budget cuts, DCHSS closed its primary care Child Health clinic in July 2007. Children needing medical care are now referred to their primary care provider or the local Federally Qualified Health Center.

As noted, with the implementation of Oregon's revised comprehensive sexuality education law on July 1, 2009 (ORS 336.455) and the concurrent elimination of funding to Oregon's STARS Program, Douglas County Public Health no longer serves as a lead for the coordination of the school-based adolescent sexual health (abstinence-only) education. These changes, along with continued budget cuts to the Public Health Division, have resulted in the discontinuation of Douglas County's Healthy Teens Coalition – a local community network that worked to raise awareness about teen pregnancy and sexually transmitted diseases, and to promote healthy choices, refusal skills, and adolescent sexual health.

DCHSS subcontracts with Umpqua Community Health Center, the local FQHC to provide a School Based Health Center at Roseburg High School and at Douglas High School in the Winston-Dillard School District.

b. Goals

Promote and improve the overall health status of children and adolescents in Douglas County through preventive health programs and services

c. Activities

a. Manage contract with FQHC to provide School Based health Center Services in Roseburg and Winston-Dillard school districts.

d. Evaluation

a. Monitor Oregon child and adolescent health data
b. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

III.12 Action Plan: Immunizations

a. Current condition

Oregon Administrative Rule 333-014-0050 establishes control of reportable communicable disease is a core public health function required by law. Control of disease includes assuring the availability of immunizations for human and animal target populations in the community.

DCHSS operates immunization clinics in Roseburg, Canyonville, Drain, Reedsport, and off-site locations. Services include the federal Vaccine for Children's (VFC) Program which helps families of children who may not otherwise have access to vaccines by providing free vaccines. VFC Program eligibility includes children 18 years old or younger who have Medicaid, are uninsured, are Native American or Alaskan native, or if their insurance doesn't cover one or all vaccines. In 2010 DCHSS administered 5621 shots under the VFC program. The LPHA is unique in the community as it also participates in the Section 317 Program which helps children and adults who may not otherwise have access to vaccines by providing free vaccines. 317 Program eligibility includes persons who are 18 years old or younger and cannot afford their insurance co-pay or deductible; or is a child or adult at risk for disease as outlined by the Oregon Immunization Program. In 2010 the LPHA administered 1268 shots under the 317 program. In FY 2010 the LPHA administered 9751 shots overall. A free 4-hour Shots for Tots clinic is held annually on a Saturday in February; in 2011 it served 162 children.

The LPHA does an annual Flu/Pneumonia campaign; flu shots are given to the home bound and flu clinics are held in areas of the county outside the Roseburg area. In 2009, DCHSS ended offering a flu clinic in the Roseburg area, reduced the number of flu shots provided in the home, and reduced the number of employers served in the flu campaign. These reductions were due to staffing cuts and due to the Roseburg area having greater access to physicians and pharmacies offering vaccine. In 2010-2011 we have continued to see a decreased demand for flu vaccine overall, likely due to DCHSS not being a preferred provider for insurance and not accepting private insurance except in limited situations. As of March 13, 2011 DCHSS has provided 1,291 doses of flu vaccine for the 2010-2011 season. In 2009, DCHSS coordinated the ordering and distribution of H1N1 influenza vaccine so that 16,804 doses of vaccine were administered to protect the County population. Unlike some counties, DCHSS has not provided school located influenza vaccine clinics; this has been in attempt to best utilize staffing to offer clinics that serve ages across the lifetime.

DCHSS uses the online Oregon ALERT registry that houses vaccination records and in 2010 the DCHSS staff used the web search and forecasting feature of ALERT over 19,000 times. Currently, DCHSS is using grant funding to improve their electronic health record system to be able to submit data real-time to the ALERT registry. In conjunction, the ALERT registry is being improved. The statewide ALERT registry system is merging with IRIS, the

immunization records system that most local public health departments use, to create ALERT IIS. This new registry collects immunization data from both public and private health care providers to create complete records for individuals in Oregon. ALERT IIS offers many new features that will save time and provide valuable information in clinical and school settings. ALERT IIS will offer more functionality for users, including a comprehensive web-based user interface and more flexibility for bidirectional exchange of data with Electronic Health Records (EHRs). Timely submission of immunization data to a registry, or real-time transmission, helps provide consolidated immunization records for new and existing patients, reduces staff time searching for a patient immunization record, helps to prevent missed opportunities or over-immunization, and helps to reduce the spread of vaccine preventable diseases by facilitating the provision of timely immunizations. Currently DCHSS staff is being trained on the ALERT IIS and we are nearing transition to an improved EHR.

A variety of evaluation is conducted by the Oregon Immunization Program to help us focus on the goal to protect Oregonians from vaccine-preventable diseases. The 2009 annual AFIX report estimates that DCHSS sees 29% of the County's 2 year olds for immunizations. It also reports that only 49% of 2 year olds seen at DCHSS were up-to-date on immunizations, compared to 65% of Oregon 2 year olds. This is in part due to a national Hib vaccine shortage in effect from December 2007 until July 2009. DCHSS was not able to get enough Hib containing vaccine to administer the primary series consistently to patients. DCHSS saw a drop in Hib rates and in overall series rates, and an increase in missed shot rates. The population based immunization rates (PBRs) reflect immunization rates for 2 year olds compiled from records submitted to ALERT from all County immunization providers, not just exclusive of DCHSS. The 2009 PBRs show 61.6% Douglas County 2 year olds are up-to-date on immunizations versus 65.5% of Oregon 2 year olds.

Management of vaccines includes: ordering vaccines; controlling inventory; storing vaccines & monitoring conditions; minimization of vaccine wastage; proper vaccine stock rotation; vaccine receiving, packing, and transporting; and emergency planning. The health department utilizes redundant temperature monitoring, including temperature tracking availability in an online system. In 2010, DCHSS installed back-up generators at the Drain and Reedsport locations, purchased new separate lab grade refrigerator and freezer units for all locations, and purchased portable refrigerator/freezer units for off-site use.

Umpqua Community Health Center (UCHC) continues as a delegate agency of DCHSS. This includes their main site, satellite offices and two School Based Health Centers. The unique contract relationship between any health department and a delegate agency that is a FQHC is that it affords the delegate access to 317 vaccines and affords the health department access to use the code F vaccine eligibility code. Code F eligibility is for any child 18 and younger that is underinsured, meaning one or more vaccines is not covered by their insurance plan. This contract relationship expands the availability of vaccines to vulnerable populations in the County. UCHC's vaccine practices are reviewed by the health department every 2 years. In early 2011 UCHC was found out of compliance with submission of adult immunization data to ALERT, UCHC was given 45 days to bring their clinics into compliance.

DCHSS administers vaccines for international travelers by appointment in Roseburg. In 2010, DCHSS served 128 County residents that planned international travel. In addition, the clinic is a certified Yellow Fever vaccine center. According to International Health Regulations, yellow fever vaccine must be administered at certified yellow fever vaccination centers. There is no other certified Yellow Fever vaccine center in Douglas County.

Perinatal Hepatitis B virus transmission can be prevented by identifying Hepatitis B infected pregnant women and providing Hepatitis B immune globulin and Hepatitis B vaccine to the infants within 12 hours of birth. Preventing perinatal transmission is an integral part of the national strategy to eliminate Hepatitis B in the United States. National guidelines call for the following: universal screening of pregnant women for HBsAg during each pregnancy; case management of HBsAg-positive mothers and their infants; provision of immunoprophylaxis for infants born to infected mothers, including Hepatitis B vaccine and Hepatitis B immune globulin; and routine vaccination of all infants with the Hepatitis B vaccine series, with the first dose administered at birth. Services in the Perinatal Hepatitis B Prevention Program include case management of 1-4 mother/child pairs a year.

Client reminder and recall interventions involve reminding members of a target population that vaccinations are due (reminders) or late (recall). Client reminder and recall interventions are recommended based on strong evidence of effectiveness in improving vaccination coverage: (1) in children and adults; (2) in a range of settings and populations; (3) when applied at different levels of scale—from individual practice settings to entire communities; (4) across a range of intervention characteristics (e.g., reminder or recall, content, theoretical basis and method of delivery); and (5) whether used alone or with additional components. DCHSS sends a reminder to each client seen previously to remind them of upcoming immunizations. DCHSS also does targeted recalls to populations seen at risk as needed; e.g. in 2010 when there was an increased incidence of bacterial meningitis cases a recall was sent to over 7,000 adolescents past due on meningococcal vaccine; when confirmed Hepatitis C virus infection, recall is sent for Hep A and Hep B vaccine; when new school law requirements are initiated, recall is sent to specific ages to encourage vaccination prior to the annual school law exclusion dates.

DCHSS shall comply with the Oregon School Immunization Law. Services include ongoing consultation with certified childcare facilities, preschools, Head Start facilities; and all schools in Douglas County. In 2010, this was 104 facilities. Annually all school files are reviewed by school Administrators, turned into DCHSS for second review and DCHSS issues letters to parents when children are not complete with their immunizations, or do not have an immunization record on file at the school. In 2011, DCHSS issued 912 letters to parents/guardians; 232 children were not in compliance by the 2 week deadline and therefore excluded from school until in compliance. Annually, the State Immunization Program and the DCHSS do targeted on-site visits for a minimum of four facilities to monitor facility compliance with School Law. In August 2010, DCHSS held clinics at four middle schools to offer adolescent immunizations during back-to-school registration; in total 215 adolescents were vaccinated.

A representative of DCHSS has membership on the Oregon Immunization Policy Advisory Team (IPAT). IPAT advises the Oregon Public Health Immunization Program on the development, prioritization and implementation of immunization policy issues. Composed of voting members who are experts in immunization and/or policy fields and non-voting members from the Department of Human Services, IPAT strives to facilitate a sound, collaborative decision-making process around immunization issues facing Oregonians. DCHSS represents the voice of local health departments in Oregon. Other members represent insurance plans, schools, family physicians and pediatric groups, policy & research, County health officers, school nurses, pharmacies, and more. Although all meetings are held in Portland, DCHSS staff attends by phone due to budget cuts.

This year, due to possible cuts in the Governor's budget, the State Immunization Program is uncertain how much impact there will be on funding passed through to county immunization programs. If the Governor makes proposed budget cuts, DCHSS could lose the entire contract with the Oregon Immunization Program for $28,845. In a memo dated March 4, 2011 from Lorraine Duncan Oregon Immunization Program (OIP) Manager, she states she does not want to ask LHDs to design and implement any new planning until we know more about what the outcome will be, budget-wise. Until we know the results of the budget cuts, OIP is only requiring LHD immunization programs to submit their annual progress report update for 2010 activities. Once the 2011-13 state budget is finalized OIP will request new plans from counties in a triennial review year.

See the attached Immunization Annual Plan for updates on 2010 activities.

b. **Goals**

a. To identify, prevent, & decrease vaccine-preventable diseases
b. To target & vaccinate high-risk populations against vaccine-preventable diseases
c. To improve public health preparedness
d. To educate the public regarding vaccine-preventable diseases
e. To maintain or improve immunization rates across the lifetime
f. To submit immunization data to ALERT IIS in nearly real-time, after QA processes
g. To have no vaccine loss due to mishandling
h. To prevent perinatal transmission of Hepatitis B
i. To comply with Oregon School Immunization law

c. **Activities**

Target population: Douglas County

a. Provide epidemiologic investigations to report, monitor, and control communicable disease and other health hazard
b. Programmatic stability with current budget forecast

c. Provide immunization clinics that include eligibility for free vaccines through VFC or 317 funding, or special project vaccine
d. Provide flu/pneumonia clinics
e. Transition to ALERT IIS
f. Continue contract with delegate agency
g. Case management of perinatal Hepatitis B mothers
h. Provide reminder/recalls on immunizations
i. Maintain vaccine accountability system
j. Implement Oregon School Immunization law

d. **Evaluation**

a. Vaccine preventable diseases rates
b. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services
c. AFIX immunization rates
d. Population based immunization rates
e. Timeliness rates of immunization data submitted to ALERT IIS
f. Results of biennial review of delegate agency; due fall 2011
g. Rates of reportable communicable vaccine preventable disease
h. Number of incomplete and no record letters mailed for school law exclusion process

III.13 Action Plan: Oral Health

a. Current condition

Douglas County is designated by the Health Resources & Services Administration (HRSA) as a dental health care shortage area. The ratio of population to dentist was last reported to be over 10,000 to 1. Inadequate dental coverage and limited access to oral health care pose a significant risk for low income children, families, and older adults. There are no fluoridated water systems in Douglas County, and county resources are geographically inaccessible due to long distances and limited access to transportation services.

Budget cuts to the Public Health Division have eliminated our capacity to pursue opportunities and partnerships for oral health screening, education, or urgent care for uninsured or under insured children and adults. The following oral health promotion services are no longer provided by our Public Health Promotion Program: community engagement activities, population-based oral health education, grant writing for school or community-based dental health screening or direct care.

Recent grants to Mercy Medical Center's Healthy Kids Outreach Program and Umpqua Community Health Center (FQHC) are helping to fill the gap in access to dental care for children in some areas of Douglas County.

See III.9 Perinatal Health section for information about Baby Smiles oral health project.

III.14 Action Plan: Nutrition and Physical Activity

a. Current condition

Poor nutrition, physical inactivity, and obesity are risk factors that increase the risk of early onset diabetes and other preventable chronic diseases. The most recent data available show that 27.7% of 8th graders and 27.7% of 11th graders in Douglas County are overweight or at risk for overweight (Oregon Healthy Teen Survey, 2007-2008). Only 20.7%% of 8th grader and 14.6% of 11th graders eat the recommended 5-a-day fruits or vegetables per day. Moreover, 64.6% of Douglas County adults are overweight or obese, as compared to 60.4% statewide (Keeping Oregonians Healthy, 2004-2007 data update).

In coordination with Douglas County's Tobacco Prevention & Education best-practice work to "Build Capacity for Chronic Disease Prevention, Early Detection, and Self-Management," our Public Health Promotion Program is able to devote time community engagement efforts, including facilitation of Healthy Active Douglas County – a group that is working to advance policies, systems and environments that promote healthy community conditions and lifestyles. In addition, we are working in partnership with the Cow Creek Band of Umpqua Tribe of Indians on a *Healthy Communities* assessment project to learn what is working in Douglas County to improve health and where improvements are possible. More information about the Douglas County Healthy Communities project is available online at http://www.co.douglas.or.us/health/ph/HealthyActive.asp.

Participation in nutrition education is addressed primarily through the Douglas County WIC Program and in coordination with health education to individuals/families who receive services through the various Public Health Division programs (e.g., Nurse Home Visit, Family Planning).

b. Goals

See Tobacco Prevention & Education workplan for 2010-2011 and 2011-2012.

See the attached 2011/2012 WIC Nutrition Education Plan, WIC Staff Training Plan, and Evaluation of 2010/2011 WIC Nutrition Education Plan.

c. Activities

See Tobacco Prevention & Education workplan for 2010-2011 and 2011-2012.

See the attached 2011/2012 WIC Nutrition Education Plan, WIC Staff Training Plan, and Evaluation of 2010/2011 WIC Nutrition Education Plan.

Target population: Douglas County

d. Evaluation

See Tobacco Prevention & Education workplan for 2010-2011 and 2011-2012.

See the attached 2011/2012 WIC Nutrition Education Plan, WIC Staff Training Plan, and Evaluation of 2010/2011 WIC Nutrition Education Plan.

III.15 Action Plan: Substance Abuse

a. Current condition

Alcohol, tobacco and other drug use affects families, schools, workplaces, and entire communities. Although we have seen a decrease in underage drinking, use of alcohol, tobacco and other drug use is higher among Douglas County youth and adults than among youth and adults statewide. Most recent data show that 34% of 8th graders and 47.7% of 11th graders reported drinking alcohol on one or more occasions in the past 30 days, a slight decrease among 8th graders (36.2%) and 11th graders (50.1%) since 2006 (Oregon Healthy Teen Survey, 2005-2006 and 2007-2008). Of those who report drinking, 15.9% of eighth graders and 29% of 11th graders reported binge drinking (5 or more drinks in a row in a couple of hours), an increase from 12% and 26% respectively in 2006. In 2008, 16.1% of 8th graders and 18.1% of 11th graders in Douglas County reported use of marijuana.

While tobacco use continues to decline in Oregon, the prevalence of tobacco use is consistently higher in Douglas County than statewide. Adult smoking continues to be significantly higher in Douglas County (27.3%) than among adults statewide (18.7%) (Oregon Tobacco Facts & Laws, 2011). Although tobacco use among Douglas County youth is higher than among youth statewide, we are encouraged by a reported decrease in use among 8th graders (15.1% in 2006 to 12.5% in 2008) and 11th graders (21.7% in 2006 to 20.1% in 2008) (Oregon Healthy Teen Survey, 2007-2008).

Tobacco use among pregnant women in Douglas County continues at an alarmingly high rate. The most recent data show that one in four infants (24.6%) are born to women who report using tobacco during pregnancy, as compared to 12.2% statewide (Oregon Tobacco Facts & Laws, 2011). Tobacco costs Douglas County residents over $115 million per year in direct medical costs and indirect costs of lost productivity due to tobacco-related death.

Douglas County Public Health Division programs include tobacco prevention education in coordination with all of its client and community-based programs and services. The Prenatal Clinic Care, Family Planning, Maternity Case Management, Babies First, Healthy Start, and WIC Programs all serve as important touch points for targeted client education about the risks of tobacco use during the preconception, pregnancy, and postpartum periods. Risk screening and counseling are important elements of all clinics and home visit encounters. See Action Plan III.9 Perinatal Health for information about reducing tobacco use during pregnancy.

Community-based tobacco prevention and education is a central component of Oregon's comprehensive tobacco control program, and essential to fulfilling Oregon's mission to advance policies, systems and environments that promote health and prevent disease. Tobacco Prevention and Education Program funding was restored to Douglas County beginning January 2008. The Public Health Promotion Program provides coordination of the grant project, including community assessment, program planning, implementation,

evaluation, and reporting. Public Health Promotion staff represent Public Health and Tobacco Prevention on local drug prevention task groups and coalitions, facilitates key stakeholder groups to carryout Tobacco Prevention and Education grant activities, and serves on regional and statewide leadership groups.

b. Goals

a. Create tobacco-free environments to reduce secondhand smoke exposure
b. Prevent tobacco initiation among youth and young adults
c. Promote quitting among youth and adults
d. Identify and eliminate disparities in tobacco use
e. Reduce the burden of tobacco related chronic disease
f. Enforce Oregon's Smokefree Workplace Law

c. Activities

a. Coordination and Collaboration, Assessment, Education and Outreach, Media Advocacy, Policy Development, and Promotion of Oregon Tobacco Quitline for five best-practices areas identified in the FY 2010/2011 Local Program Plan:
    1. Building Capacity for Chronic Disease Prevention, Early Detection, and Self-Management
    2. Tobacco Free Worksites
    3. Enforcement of the Indoor Clean Air Act
    4. Smokefree Multi-Unit Housing
    5. Tobacco-Free Community College
b. Provide tobacco prevention education in coordination with Public Health Division Programs
c. Represent Douglas County Public Health Division and Public Health Promotion on state, regional and local drug prevention committees and coalitions

Target population: Douglas County

d. Evaluation

a. Monitor local data on alcohol, tobacco, and other drug abuse in Douglas County, e.g., Oregon Healthy Teen Survey, Behavioral Risk Factor Surveillance System, Oregon Tobacco Facts & Laws, County Healthy Rankings, Oregon Benchmark reports
b. Quarterly reports and program evaluation as required in coordination with Tobacco Prevention & Education Program guidelines and contact agreement with the Oregon Health Authority.

III.16 Action Plan: Child Injury Prevention

a. Current condition

Unintentional injury is the number causes of injury and death in Oregon. Each year, more than 2,000 Oregonians die as a result of injury, and nearly 20,000 are hospitalized as a direct result of injuries. According to a 2008 report compiled by the Oregon Department of Human Services, Injury Prevention & Epidemiology Program, the leading causes of unintentional injury to Douglas County children residents are: motor vehicle traffic-related injuries, falls, and poisoning.

As a result of continued budget cuts, Douglas County Public Health has discontinued all community-based child injury prevention programs, including child passenger safety seat education and distribution for low income families, bike helmet safety education, and other community-based injury prevention initiatives or campaigns.

In accordance with ORS 714.747, the Douglas County Public Health Division is part of the local interagency Child Fatality Review Team (CFRT) to review child deaths that are "unexpected," including deaths from unintentional injuries, intentional injuries (homicide and suicide), SIDS and unexpected deaths due to natural causes.

Child injury prevention education (e.g., crib safety, fall prevention, home safety, poisoning and burn prevention) continues to be an important element of Public Health Division Maternity Case Management and Babies First!

b. Goals

a. To help reduce child injury through education and outreach to families served by the Douglas County Maternity Case Management Program.
b. To identify circumstances with public health significance leading to child fatality.
c. To ensure public health perspective in agency response and identification of the cause and manner of child fatalities.

c. Activities

a. Promote child injury prevention through Public Health Division programs, e.g., Nurse Home Visit, Babies First!
b. Participate in local Child Fatality Review Team review meetings

Target population: Douglas County

d. Evaluation

b. Number of families receiving education and information about safe sleeping, child passenger safety seats, home safety, and other child injury prevention information as measured by number of home visits per year.
c. Number of child fatality review meetings attended
d. Number of child fatalities reviewed

III.17 Action Plan: Health Statistics

a. **Current condition**

Birth and death reporting, recording, and registration are provided by the DCHSS Roseburg office. In 2006, DCHSS implemented electronic death registration with funeral homes. Only one county physician participates in electronic death registration. DCHSS implemented electronic birth certificates in January 2008.

Assessment of mortality and morbidity trends and other public health statistic information is conducted and analyzed on a routine basis in order to assess the state of health in Douglas County and identify populations at risk for the provision of intervention services.

The Deputy Medical Examiner, with the Douglas County Sheriff's Office, notifies DCHSS of all child deaths, unusual deaths that may have public health significance, and deaths related to communicable diseases. Child deaths are reviewed by the Douglas County Child Fatality Review Team. Cases of attempted suicide are also reviewed by this team. The Medical Examiner serves multiple Southern Oregon counties and works out of Three Rivers Hospital, Grants Pass.

b. **Goals**

a. One hundred percent (100%) of birth and death certificates that are submitted to the Douglas County Vital Records Office are reviewed by the County Registrar or a Deputy Registrar for accuracy and completeness following established Vital Records Office procedures prior to registration and issuance of certificates
b. Records are re-verified as complete and accurate at the time the originals are entered into the county computer database
c. Assure accurate, timely and confidential certification of birth and death events
d. 100% of birth and death certificates are provided within 24 hours of receipt, unless order received prior to original certificate or some other extenuating circumstance prevents its issuance
e. Analysis of public health information gathered from birth and death certificate data will contribute to proactive intervention to improve public health

c. **Activities**

Target population: Douglas County

a. Data collection and analysis of health indicators related to morbidity and mortality
b. Birth and death reporting, recording, and registration
c. Analysis of services provided with technical assistance from the Department of Human Services

d. Requests from walk-in customers are filled while the customer waits, once the customer's identification has been proven, their right to obtain a copy of the record has been established, and payment made. Certified copies of registered birth and death certificates are issued within one (1) working day of request.
e. Death certificates are usually ordered by the funeral home. One hundred percent (100%) of these orders are filled within 24 hours of receipt of the request, unless extenuating circumstances occur.
f. Birth and death certificates are ordered by customers. Once the foregoing criteria are established, the certificate is mailed or picked up at the Roseburg Vital Records office.

d. **Evaluation**

a. One hundred percent (100%) of birth and death certificates provided within 24 hours of receipt, unless extenuating circumstances occur.
b. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

III.18 Action Plan: Information and Referral

a. Current condition

DCHSS provides accurate and unbiased information and referral about local health and social services to the citizens of Douglas County. Information and referral is provided through response to telephone inquiries, providing information and referral information through news releases, presentations, printed materials, the County's website, and by communicating in-person to DCHSS clients.

DCHSS telephone numbers and facility addresses are listed in phone directories, local newspapers, brochures, local and state websites, and community resource directories. The Roseburg DCHSS reception operates on Monday to Friday 8 am to 5 pm. DCHSS reception for outlying clinics in Canyonville, Drain, and Reedsport operate on the following days only: Canyonville – Tuesday, Wednesday, Thursday 8 am to 5 pm; Drain – Wednesday, Thursday 8 am to 5 pm and Fridays 8 am to 4 pm; Reedsport – Mondays and Tuesdays 9 am to 4 pm. Specific program clinic hours i.e. Immunizations, Family Planning advertised on clinic cards, website and said locations.

DCHSS currently has one Public Health Nurse that is out-stationed to the Self-Sufficiency & Employment Program, Department of Human Services, SDA District 6 office. This nurse provide health information and referral services to Children and Family Services clients. In FY 2011 2012 this position will be eliminated with reductions to the Self Sufficiency Program

DCHSS provides information and referrals that are culturally appropriate. DCHSS utilizes a Portland-based interpreter telephone service and three local contracted translators as necessary for language translation including updating program specific forms.

The Public Health Division serves as a local resource to the community for information and data concerning the specific public health issues confronting the Douglas County community.

b. Goals

a. To provide timely and accurate Public Health information on the DCHSS webpage
b. To integrate functions within DCHSS to streamline services from all divisions, providing better service to customers
c. To distribute Public Health information via local media releases

c. Activities

Target population: Douglas County

a. Review and revision of phone book listings to ensure accuracy and ease of use

b. All brochures and other resources are reviewed annually and updated as needed

d. Evaluation

a. Public Health customer satisfaction survey
b. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

IV. Additional Requirements

a. See the attached organizational chart of the local health department

b. The Douglas County Board of County Commissioners is comprised of three elected individuals. The Board of Commissioners meets weekly on Wednesdays at 9am. One commissioner is assigned to the Health and Social Services Department as a liaison commissioner. The administrator attends the weekly board of commissioner meetings, and also meets with the assigned liaison commissioner every 1-2 weeks. These meetings are to discuss operational issues, concerns for the department.

c. The Public Health Division has a taskforce that meets 3-4 times per year to receive updates in program issues, review and approve any additional material for the client population. This group is comprised of physicians (OB/GYN), managed care partners, hospital partners, local CCF, school superintendent, DHS Service Area Director, member from FQHC, Department of Justice, and local program staff. During this last year the taskforce has been challenged to identify a solution to the closure of the Douglas County Prenatal Clinic. The result of multiple meetings is a collaborative approach to clinic operations between the hospital, managed care provider, FQHC and Douglas County. This plan will allow women to continue to receive integrated care at a familiar and accessible location. This allow for seamless connection between pregnancy testing services and prenatal care.

d. Triennial Review: All identified compliance items were resolved in December of 2009.

e. Senate Bill 555: The Douglas County Commission on Children and Families (CCF) is under the governance of the Douglas County Board of Commissioners. The local Commission director and the DCHSS Public Health Division Director have established a working relationship to provide services and care to children and families of Douglas County. The Public Health Division Director has been involved from the early planning phases of all parts of the Senate 555 Plan. Together, the Public Health Division Director and the local CCF Director have coordinated trainings for the community on child development, brain research, and have worked closely with the community to have a smooth, coordinated home visit program between Babies First/Maternity Case Management and Healthy Start.

V. Unmet Needs

a. Adequate Funding for Public Health

Douglas County continues to have many unmet public health needs, the largest of which is lack of public health funding. Continued budget cuts to the Public Health Division in fiscal year 2008-2009 and in the next four years will exacerbate an already diminished capacity to provide basic public health services, much less to respond to threats to public health. Rural timber communities across Oregon and the nation have historically received federal timber funding. This funding source is expected to end effective July 1, 2011.

In anticipation of the loss of funding, the Douglas County Public Health Division was instructed by the Board of Commissioners to cut the Public Health Division budget for 2011/2012 by $288,096.

The Board of Commissioners will contribute County General Fund to the Public Health Division budget to shore up Public Health Services during fiscal year 2011-2012, but the long-term sustainability of Public Health and other county services remains uncertain. In an effort to meet program requirements, the Public Health Division will pursue partnerships and funding opportunities, and will continue to educate the public about the importance of public health.

Douglas County's public health infrastructure has declined over the past several years. Inadequate funding to Public Health continues negatively impact on our ability to provide both basic and other public health services. In fiscal year 2004-2005, the Public Health Division had a budget that supported 64.7 FTE. In fiscal year 2009-2010, the Public Health Division will have an expected staffing of 43.0 FTE. With a reduction in staff comes a reduction in services, reduction in revenue, and a reduction in matching funds. A cut of this magnitude has had and will continue to have a far-reaching impact on all Public Health Programs and the health of our community.

As the silent insurance policy for all county citizens, Public Health at the local, regional, state, and national level is failing its citizens and the citizens. The short-term impact of reduced or eliminated public health services will lead to long-term effects on the health of children, families, and communities throughout Douglas County and Oregon. Funding public health is not a short-term fix, but a long-term solution.

b. Substance Abuse

A public health priority in Douglas County, and all communities, is the substance abuse—including tobacco, alcohol, prescription drug abuse, methamphetamine and

other and other illegal drug use. Substance abuse during pregnancy, among youth, and adults is widespread and takes a huge toll on entire communities. Continued budget cuts to Douglas County Public Health and to Public Health throughout Oregon have begun to erode upstream efforts to prevent substance abuse and its short and long-term costs and consequences. Funding decisions must be reprioritized and redirected to prevent the conditions that lead to substance abuse. The Public Health Division will continue to provide staff support and expertise to local efforts to address the problem of substance abuse in Douglas County.

c. Inadequate Public Transportation

Douglas County is geographically larger than the state of Connecticut. The vast majority of health and social services are located in the City of Roseburg core area. At best, mobility services in Douglas County are uneven. Although special transportation needs generally far outstrip current capacity and funding, and are often affected by geographic barriers, some needs are better served than others. For example, unmet mobility needs are greatest in the smaller towns and unincorporated rural areas of the County where transportation service is limited or nonexistent. However, more of those needs are being met in the Roseburg area, which is served by four public transit routes and a Dial-a-Ride service.

d. Urgent Care as Primary Care

Non-urgent use of emergency rooms is an indicator of a growing public health concern. When hospital emergency rooms and urgent care clinics are used for primary care, recipients of care do not receive efficient, coordinated and continuous care. Those who rely on emergency rooms for primary care are typically those who are most at risk of poor physical, oral, and mental health—uninsured, underinsured children, pregnant women, adults, and the elderly. Budget cuts to public health services for uninsured and underinsured residents guarantee an increase in non-urgent emergency room visits and a corresponding increase in costs to taxpayers.

Public Health in Douglas County and in Oregon has been weakened by a long succession of cutbacks and shifting priorities. Public health capacity in Douglas County, in Oregon, and nationally is in need of rebuilding not further shrinkage. State and federal funding decisions must prioritize upstream public health efforts to reduce the escalating costs and consequences of downstream public health problems. Unfortunately, it is the more vulnerable among us—uninsured and underinsured children, pregnant women, and elderly, and others who count on public health—are the ones who are hit harder and faster by a weakened public health infrastructure.

For those who are more fortunate, public health is largely invisible until there is a food borne illness outbreak at a church picnic, their child's daycare is closed due to an outbreak of pertussis, or there is a flu outbreak or threat of new super-bug, or media

attention to a nationwide disease outbreak related to a contaminated food product. Only a public health system that has the capacity to meet day-to-day health challenges will have the capacity needed to prevent or respond to public health threats and emergencies.

VI. Budget

The Douglas County Health and Social Services budget planning for Fiscal Year 2009/2010 is currently in progress. Final approval will come prior to June 30, 2011. DHS can obtain a copy of the budget document from the following contact:

Douglas County Health and Social Services

Attention: Marsha Price, Management Analyst

621 West Madrone

Roseburg, OR 97470

(541) 440 – 3613

VII. Minimum Standards

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

Organization

1. Yes __x_ No ___ A Local Health Authority exists which has accepted the legal responsibilities for public health as defined by Oregon Law.

2. Yes _x__ No ___ The Local Health Authority meets at least annually to address public health concerns.

3. Yes _x__ 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 __x_ No ___ Current local health department policies and procedures exist which are reviewed at least annually.

5. Yes _x__ No ___ Ongoing community assessment is performed to analyze and evaluate community data.

6. Yes _x__ No ___ Written plans are developed with problem statements, objectives, activities, projected services, and evaluation criteria.

7. Yes _x__ No ___ Local health officials develop and manage an annual operating budget.

8. Yes _x__ No ___ Generally accepted public accounting practices are used for managing funds.

9. Yes _x__ No ___ All revenues generated from public health services are allocated to public health programs.

10. Yes _x__ No ___ Written personnel policies and procedures are in compliance with federal and state laws and regulations.

11. Yes _x__ No ___ Personnel policies and procedures are available for all employees.

12. Yes _x__ No ___ All positions have written job descriptions, including minimum qualifications.

13. Yes _x__ No ___ Written performance evaluations are done annually.

14. Yes _x__ No ___ Evidence of staff development activities exists.

15. Yes _x_ No ___ Personnel records for all terminated employees are retained consistently with State Archives rules.

16. Yes _x__ No ___ Records include minimum information required by each program.

17. Yes _x__ No ___ A records manual of all forms used is reviewed annually.

18. Yes _x__ No ___ There is a written policy for maintaining confidentiality of all client records which includes guidelines for release of client information.

19. Yes _x__ No ___ Filing and retrieval of health records follow written procedures.

20. Yes _x__ No ___ Retention and destruction of records follow written procedures and are consistent with State Archives rules.

21. Yes _x__ No ___ Local health department telephone numbers and facilities' addresses are publicized.

22. Yes _x__ No ___ Health information and referral services are available during regular business hours.

23. Yes _x__ 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 _x__ No ___ 100% of birth and death certificates submitted by local health departments are reviewed by the local Registrar for accuracy and completeness per Vital Records office procedures.

25. Yes _x__ No ___ To preserve the confidentiality and security of non-public abstracts, all vital records and all accompanying documents are maintained.

26. Yes _x__ No ___ Certified copies of registered birth and death certificates are issued within one working day of request.

27. Yes _x__ 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 _x__ No ___ A system to obtain reports of deaths of public health significance is in place.

29. Yes _x__ 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 _x__ No ___ Health department administration and county medical examiner review collaborative efforts at least annually.

31. Yes _x__ No ___ Staff is knowledgeable of and has participated in the development of the county's emergency plan.

32. Yes _x__ No ___ Written policies and procedures exist to guide staff in responding to an emergency.

33. Yes _x__ No ___ Staff participate periodically in emergency preparedness exercises and upgrade response plans accordingly.

34. Yes _x__ No ___ Written policies and procedures exist to guide staff and volunteers in maintaining appropriate confidentiality standards.

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

38. Yes _x__ 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 _x__ 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 _x__ 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 _x__ 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 _x__ No ___ There is a mechanism for reporting and following up on zoonotic diseases to the local health department.

43. Yes _x__ No ___ A system exists for the surveillance and analysis of the incidence and prevalence of communicable diseases.

44. Yes _x__ 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 _x__ No ___ Immunizations for human target populations are available within the local health department jurisdiction.

46. Yes _x__ No ___ Rabies immunizations for animal target populations are available within the local health department jurisdiction.

Environmental Health

47. Yes _x__ No ___ Food service facilities are licensed and inspected as required by Chapter 333 Division 12.

48. Yes _x__ No ___ Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.

49. Yes _x__ No ___ Training in first aid for choking is available for food service workers. (We provide a handout card describing first-aid for choking. Training is provided in the community.)

50. Yes _x__ No ___ Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided. (We provide information to food handlers and complainants. We also provide brochures and information via the Health Department website.)

51. Yes _x__ No ___ Each drinking water system conducts water quality monitoring and maintains testing frequencies based on the size and classification of system.

52. Yes _x__ No ___ Each drinking water system is monitored for compliance with applicable standards based on system size, type, and epidemiological risk.

53. Yes _x__ No ___ Compliance assistance is provided to public water systems that violate requirements.

54. Yes _x__ No ___ All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken.

55. Yes _x__ No ___ A written plan exists for responding to emergencies involving public water systems.

56. Yes _x__ No ___ Information for developing a safe water supply is available to people using on-site individual wells and springs.

57. Yes ___ No _x__ A program exists to monitor, issue permits, and inspect on-site sewage disposal systems. (This is accomplished through the Planning Department)

58. Yes __x_ No ___ Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.

59. Yes _x__ No ___ School and public facilities food service operations are inspected for health and safety risks.

60. Yes _x__ 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 __x_ A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste. (This is provided through County Public Works.)

62. Yes _x__ No ___ Indoor clean air complaints in licensed facilities are investigated.

63. Yes _x__ No ___ Environmental contamination potentially impacting public health or the environment is investigated.

64. Yes _x__ No ___ The health and safety of the public is being protected through hazardous incidence investigation and response.

65. Yes _x__ No ___ Emergency environmental health and sanitation are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control.

66. Yes _x__ 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 _x__ No ___ Culturally and linguistically appropriate health education components with appropriate materials and methods will be integrated within programs.

68. Yes _x__ No ___ The health department provides and/or refers to community resources for health education/health promotion.

69. Yes _x__ No ___ The health department provides leadership in developing community partnerships to provide health education and health promotion resources for the community.

70. Yes _x__ No ___ Local health department supports healthy behaviors among employees.

71. Yes _x__ No ___ Local health department supports continued education and training of staff to provide effective health education.

72. Yes _x__ No ___ All health department facilities are smoke free.

Nutrition

73. Yes _x__ 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 _x__ No ___ WIC
    b. Yes _x__ No ___ Family Planning
    c. Yes _x__ No ___ Parent and Child Health
    d. Yes ___ No _x_ Older Adult Health
    e. Yes ___ No _x_ Corrections Health

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

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

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

Older Adult Health

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

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

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

Parent and Child Health

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

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

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

85. Yes _x__ No ___ Services for the early detection and follow up of abnormal growth, development and other health problems of infants and children are provided directly or by referral.

86. Yes _x__ No ___ Child abuse prevention and treatment services are provided directly or by referral.

87. Yes _x_ No ___ There is a system or mechanism in place to assure participation in multi-disciplinary teams addressing abuse and domestic violence.

88. Yes _x__ No ___ There is a system in place for identifying and following up on high risk infants.

89. Yes _x__ No ___ There is a system in place to follow up on all reported SIDS deaths.

90. Yes _x__ No ___ Preventive oral health services are provided directly or by referral.

91. Yes _x__ No ___ Use of fluoride is promoted, either through water fluoridation or use of fluoride mouth rinse or tablets.

92. Yes _x__ No ___ Injury prevention services are provided within the community.

Primary Health Care

93. Yes _x__ No ___ The local health department identifies barriers to primary health care services.

94. Yes _x__ No ___ The local health department participates and provides leadership in community efforts to secure or establish and maintain adequate primary health care.

95. Yes _x__ No ___ The local health department advocates for individuals who are prevented from receiving timely and adequate primary health care.

96. Yes _x__ No ___ Primary health care services are provided directly or by referral.

97. Yes _x__ No ___ The local health department promotes primary health care that is culturally and linguistically appropriate for community members.

98. Yes _x__ No ___ The local health department advocates for data collection and analysis for development of population based prevention strategies.

Cultural Competency

99. Yes _x__ No ___ The local health department develops and maintains a current demographic and cultural profile of the community to identify needs and interventions.

100. Yes _x__ 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 _x__ No ___ The local health department assures that advisory groups reflect the population to be served.

102. Yes _x__ No ___ The local health department assures that program activities reflect operation plans for provision of culturally and linguistically appropriate services.

Health Department Personnel Qualifications

Local health department Health Administrator minimum qualifications:

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

Administrator name: Peggy Kennerly

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

1. **Yes ___ No _x_ The local health department Health Administrator meets minimum qualifications:**

   As Health Department Administrator I am also responsible for Mental Health, Developmental Disabilities Services, Senior Services, Volunteer Services, Veteran Services and Public Transportation. With the increased workload it has not been possible to add online classes to the work day.

   Peggy Madison, Douglas County Health & Social Services

2. **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.

3. **Yes _x__ No ___ The local health department Environmental Health Supervisor meets minimum qualifications:**

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

   OR

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

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

4. **Yes _x__ No____ The local health department Health Officer meets minimum qualifications:**

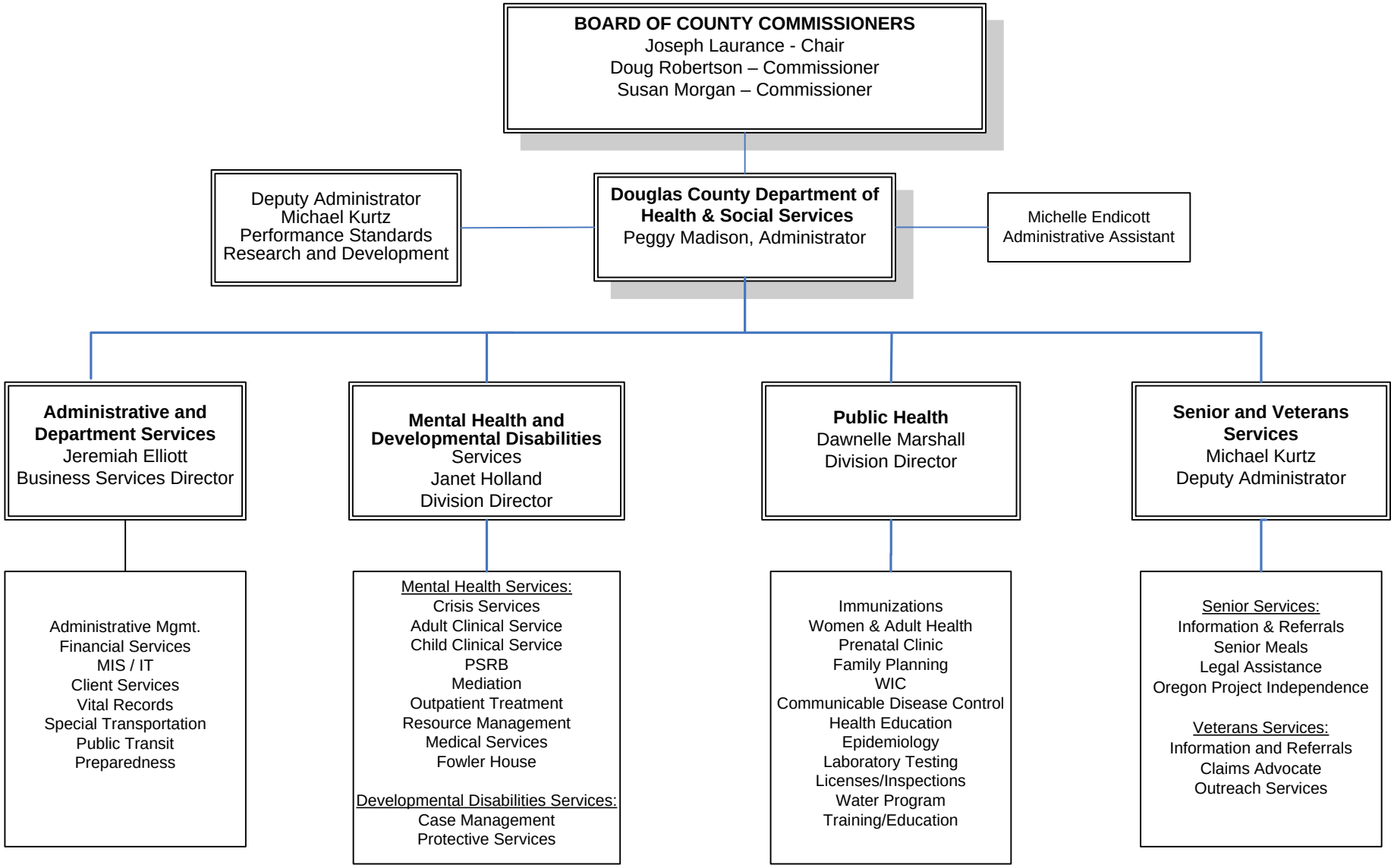
   Licensed in the State of Oregon as M.D. or D.O. Two years of practice as licensed physician (two years after internship and/or residency). Training and/or experience in epidemiology and public health.

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

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

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

Peggy Madison Digitally signed by Peggy Madison DN: cn=Peggy Madison, o=Douglas County Health and Social Services, ou=Health Administrator, email=pemadison@co.douglas.or.us, c=US Date: 2011.04.22 11:17:04 -07'00'	Douglas	04/22/2011
Local Public Health Authority	County	Date


BOARD OF COUNTY COMMISSIONERS
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Case Management
Protective Services
Immunizations
Women & Adult Health
Prenatal Clinic
Family Planning
WIC
Communicable Disease Control
Health Education
Epidemiology
Laboratory Testing
Licenses/Inspections
Water Program
Training/Education
Senior Services:
Information & Referrals
Senior Meals
Legal Assistance
Oregon Project Independence
Veterans Services:
Information and Referrals
Claims Advocate
Outreach Services

Immunization Comprehensive Triennial Plan

Due Date: May 1
Every year

Local Health Department:
Plan A - Continuous Quality Improvement: Reduce Vaccine Preventable Disease
Calendar Years 2009-2011

Year 1: July 2009-December 2009

Objectives	Activities	Date Due / Staff Responsible		Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. **Increase Douglas Health Department rate of 24 month olds with their 4th DTaP by 10% over 3 years**	o Analyze and QA cohort in 2008 rates to see if 4th DTaP before 24 months of age and who was provider of 4th DTaP o Provide staff training to include the following: o Review consistency of screening children for 4th DTaP at 12 months or at minimum spacing after 3rd dose o Strategies to improve 4th DTaP o Vaccine safety education and talking to hesitant parents o Forecasting all childhood immunizations using IRIS or	04/09 Ongoing	Hofford Hofford	O Baseline set O Training held for WIC staff on ____. O Recall/reminder system forecast changed on ____. O All staff trained to talk with parents and able to answer questions about vaccine safety o Staff trained and understand policy of giving all shots due unless parent refuses even after education & counseling o Roseburg clinic practices changed in 04/09. o Drain clinic practices changed	Staff meeting in April 2010 requested 4th DTaP be given at minimal interval. Staff reports it has not been implemented routinely. QA of 2008 AFIX cohort revealed no unusual findings. Annual AFIX rates distributed to clinical staff. The following did not occur as outcome measures due to staff being redirected to H1N1 response: WIC training, focused staff training, internal monitoring of WIC 4th DTaP screening process, monitoring of staff practice changes in Roseburg,	Many factors contribute to rates going up and down, some of which include: LHD stopped taking private insurance for shots in February 2009, local economic factors, budget and staff reductions at LHD, H1N1 response. In addition, the LHD changed to a new data system in July 2009. Progress notes to be completed further after LHD receives 2009 AFIX rates from Oregon Immunization Program.

	ALERT. o Review consistency of screening WIC children for 4th DTaP o Change clinic practices in Roseburg site to start giving 4th DTaP at 1 year of age if minimum spacing met o Change clinic practices in satellite sites to start giving 4th DTaP at 1 year of age if minimum spacing met o Use combination vaccines to minimize # shots given at any visit o Change reminder/recall system to send postcard at 12 months of age versus 15 mo of age	07/09 05/09 05/09 ongoing 04/09	Hofford Sickler Geier and Siling All Hofford	on ____. o Canyonville clinic practices changed in _____. o Reedsport clinic practices changed in -_____.	implementation in outlying clinics. LHD postcard reminder/recalls changed April 2009 to remind/recall at 12 months of age rather than 15 months of age. Birth cohort reminder/recall postcards were not sent timely in 2009 due to H1N1 response. 2 DAs and 3 nurses attended 2009 Oregon Immunization Conference. Checked with ALERT in 2010; verified that they forecast in 4th DTaP in ALERT at 12 months of age and recall for all antigens at 22 months of age. Additional outcome measure results to be completed after LHD receives 2009 AFIX rates from Oregon Immunization Program.	

Due Date: May 1 Every Year

Immunization Comprehensive Triennial Plan

Local Health Department:
Plan A - Continuous Quality Improvement: Reduce Vaccine Preventable Disease
Calendar Years 2009-2011

Year 2: January 2010-December 2010

Objectives	Activities	Date Due / Staff Responsible		Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. **Increase Douglas Health Department rate of 24 month olds with their 4th DTaP by 10% over 3 years**	o Continue staff training to include the following: o Review consistency of screening children for 4th DTaP at 12 months or at minimum spacing after 3rd dose o Strategies to improve 4th DTaP o Vaccine safety education and talking to hesitant parents o Forecasting all childhood immunizations using IRIS or ALERT. o Review again consistency of screening WIC children for 4th DTaP o Review County 4th DTaP 2009 immunization rates	Due To be scheduled in 2010	Staff To be assigned in 2010	O All staff trained to talk with parents and able to answer questions about vaccine safety O Staff trained and understands policy of giving all shots due unless parent refuses even after education & counseling___.	O Douglas Co AFIX 4th DTaP rate for 2008 = 66% O Douglas Co AFIX 4th DTaP rate for 2009 = 61% O Douglas Co PBR 4th DTaP rate for 2008 = 69.8% O Douglas Co PBR 4th DTaP rate for 2009 = 77.6% O Oregon PBR 4th DTaP rate for	Many factors contribute to rates going up and down, some of which include: LHD stopped taking private insurance for shots in February 2009, local economic factors, budget and staff reductions at LHD, Douglas County clinics seeing less children 0-12 months than year previous, transition of data systems in July 2009 from CHMC to Profiler, transition of data systems in March 2011 from Profiler to improved Profiler and from ALERT to ALERT IIS. Children who move out of the clinic or out

Year 2: January 2010-December 2010						
Objectives	**Activities**	**Date Due / Staff Responsible**		**Outcome Measure(s)**	**Outcome Measure(s) Results**	**Progress Notes**
	o Review County 4th DTaP 2009 immunization rates for satellite clinics o Use combination vaccines to minimize # shots given at any visit				2009 = 83.3% o Staff attended 2010 Oregon Immunization Conference	of state are impossible to track in data systems leaving a inflated denominator to calculate rates. Douglas County has worked with State to look for clinics that are providing immunizations in County but not submitting data to ALERT, therefore, children are in ALERT with only partial records. Due to possible budget cuts, Douglas County cannot speak to the ability to continue to work on this objective in 2011.

Immunization Comprehensive Triennial Plan

Due Date: May 1
Every year

Local Health Department:
Plan A - Continuous Quality Improvement: Reduce Vaccine Preventable Disease
Calendar Years 2009-2011

Year 3: January 2011-December 2011

Objectives	Activities	Date Due / Staff Responsible		Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. **Increase Douglas Health Department rate of 24 month olds with their 4th DTaP by 10% over 3 years**	o Continue staff training to include the following: o Review consistency of screening children for 4th DTaP at 12 months or at minimum spacing after 3rd dose o Strategies to improve 4th DTaP o Vaccine safety education and talking to hesitant parents o Forecasting all childhood immunizations using IRIS or ALERT. o Review again consistency of screening WIC children for 4th DTaP o Review County 4th DTaP 2010 immunization rates o Review County 4th DTaP 2010 immunization rates for satellite clinics o Use combination vaccines to minimize # shots given at any visit	Due To be scheduled in 2011	Staff To be assigned in 2011	O All staff trained to talk with parents and able to answer questions about vaccine safety O Staff trained and understand policy of giving all shots due unless parent refuses even after education & counseling	To be completed for the CY 2011 Report	To be completed for the CY 2011 Report

Immunization Comprehensive Triennial Plan

Due Date: May 1
Every year

Local Health Department:
Plan B – Community Outreach and Education
Calendar Years 2009-2011

Year 1: July 2009-December 2009

Objectives	Activities	Date Due / Staff Responsible		Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. **Douglas County will promote adolescent immunizations, including Tdap**	O Obtain up-to-date mailing lists from 6th grade schools O Mail adolescent postcard reminder to 6th graders O Pre-event activities to include: o Commit staff time and resources to project o Contact 5 middle schools to schedule clinics @ back to school registrations o Determine costs, staff time	04/09 ongoing from 04/09 thru 12/09 04/09 – 09/09	Hofford Hofford Vian/Hofford	O Pre-event activities completed (i.e., cost eval, phone calls, flyers, site set up, etc.) O Number of adolescent postcard reminders mailed in 2009 O Number of adolescents vaccinated at registration clinics: ____ O 2009-10 Tdap rate to increase by 1% from 2008's 95.74% in 7th grade exclusion rates O 2009 HPV doses increased by 50 doses from 483 in 2008	O 08/13/09 Coffenberry clinic held; 41 students vaccinated O 08/18/09 Joseph Lane clinic held; 55 students vaccinated O 08/19/09 Winston clinic held; 28 students vaccinated O 08/20/09 Fremont clinic held; 52 students vaccinated O 08/21/09 Sutherlin clinic	Targeting the largest middle schools and working with schools to schedule 7th grade back-to-school registration on separate days was a good use of limited staff time and resources. We feel that having back-to-school Tdap clinics takes the burden off of the annual Shots for Tots clinic and the school exclusion process as it helps distribute Tdap demand throughout the

Year 1: July 2009-December 2009						
Objectives	**Activities**	**Date Due / Staff Responsible**		**Outcome Measure(s)**	**Outcome Measure(s) Results**	**Progress Notes**
	needed, whether financial assistance is available (from county budget, State IZ program or vaccine company(ies)) o Decide on time, date, place and content of events o Send "Save the Date" flyers thru registration mailings o Provide pre- and day of event staffing O Host events @ Jo Lane, Fremont, Coffenberry, Sutherlin, and Winston middle schools. O Evaluate event success to modify	08/09 09/09	4 nurses 4 DAs per clinic Vian Hofford Nurses DAs	O 2009 Meningococcal doses increased by 50 doses from 398 in 2008 O Eval of reminders and events and modification for following years' events completed o Evaluation results___	held; 27 students vaccinated O 2009-2010 Tdap rate in 7th graders 96.5% O 2009 HPV 313 doses O 2009 Meningococcal 385 doses O Approximately 1500 postcards mailed to 6th and 7th graders in 2009	year. Other adolescent antigens did not increase and we gave 883 Tdap shots (all ages) in 2009, compared with 1187 Tdap shots (all ages in 2008. Douglas County will likely continue targeted middle school back-to-school clinics in August 2010. Many factors contribute to rates going up and down, some of which include: LHD stopped taking private insurance for shots in February 2009, local economic factors, budget and staff reductions at LHD, H1N1 response. In

Year 1: July 2009-December 2009						
Objectives	**Activities**	**Date Due / Staff Responsible**		**Outcome Measure(s)**	**Outcome Measure(s) Results**	**Progress Notes**
	future activities					addition, the LHD changed to a new data system in July 2009.

Due Date: May 1
Every Year

Immunization Comprehensive Triennial Plan

Local Health Department:
Plan B – Community Outreach and Education
Calendar Years 2009-2011

Year 2: January-December 2010

Objectives	Activities	Date Due / Staff Responsible		Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. **Douglas County will promote adolescent immunizations, including Tdap**	o Obtain up-to-date mailing lists from 6th grade schools o Mail adolescent postcard reminder to 6th graders o Pre-event activities include: o Commit staff time and resources to project o Contact 5 middle schools to schedule clinics @ back to school registrations o Determine costs, staff time needed, whether	Due To be scheduled in 2010	Staff To be assigned in 2010	o Pre-event activities completed (i.e., cost eval, phone calls, flyers, site set up, etc.) o Number of adolescent postcard reminders mailed in 2010 o Number of adolescents vaccinated at registration clinics: ____ o 2010-11 Tdap rate to increase by 1% from 2009's 7th grade exclusion rates o 2010 HPV doses increased by 50 doses from 2009	o 08/12/10 Coffenberry clinic held; 37 students vaccinated o 08/17/10 Joseph Lane clinic held; 67 students vaccinated o 08/18/10 Sutherlin clinic held; 31 students vaccinated o 08/19/10 Fremont clinic held; 80 students vaccinated	Douglas County met or exceeded the Tdap outcome measures for 2010. Targeting the largest middle schools and working with schools to schedule 7th grade back-to-school registration on separate days was a good use of limited staff time and resources. We feel that having back-to-school Tdap clinics takes the burden off of the annual Shots for Tots clinic and the school exclusion process as it helps distribute Tdap

Year 2: January-December 2010						
Objectives	**Activities**	**Date Due / Staff Responsible**		**Outcome Measure(s)**	**Outcome Measure(s) Results**	**Progress Notes**
	financial assistance is available - from county budget, State IZ program or vaccine company(s) o Decide on time, date, place and content of events o Send "Save the Date" flyers thru registration mailings o Provide pre- and day of event staffing O Host events @ Coffenberry Jo Lane, Fremont, Sutherlin, and Winston middle schools. O Evaluate event success to modify future activities			O 2010 Meningococcal doses increased by 50 doses from 2009 O Eval of reminders and events and modification for following years' events completed o Evaluation results___	O 2010-2011 Tdap rate in 7th graders 97.59, up from 96.5% the school year before O 2010 Tdap 658 doses given in ages 11-18, down from 712 doses in 2009 O 2010 HPV 434 doses given in ages 11-18, up from 324 doses in 2009 O 2010 Mening 566 doses given in ages 11-18, up from 369 doses in 2009	demand throughout the year. Unlike last year, although we gave less Tdap than the year prior, we saw other adolescent. Many factors contribute to dose numbers going up and down, some of which include: local economic factors, budget and staff reductions at LHD, Mening recall, HPV special project for 19 and older probably inspires FP staff to increase HPV use in across all ages. Due to possible budget cuts, Douglas County cannot speak to the ability to staff targeted middle school back-to-school clinics in August 2011.

Year 2: January-December 2010						
Objectives	**Activities**	**Date Due / Staff Responsible**		**Outcome Measure(s)**	**Outcome Measure(s) Results**	**Progress Notes**
					O Estimated over 7,000 postcards mailed to adolescents in 2010	

Immunization Comprehensive Triennial Plan

Due Date: May 1 Every Year

Local Health Department:
Plan B – Community Outreach and Education
Calendar Years 2009-2011

Year 3: January 2011-December 2011

Objectives	Activities	Date Due / Staff Responsible		Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. **Douglas County will promote adolescent immunizations, including Tdap**	o Obtain up-to-date mailing lists from 6th grade schools o Mail adolescent postcard reminder to 6th graders o Pre-event activities include: o Commit staff time and resources to project o Contact 5 middle schools to schedule clinics @ back to school registrations o Determine costs, staff time needed, whether financial assistance is available (from county budget, State IZ program or vaccine company(ies)) o Decide on time, date,	Due To be scheduled in 2011	Staff To be assigned in 2011	o Pre-event activities completed (i.e., cost eval, phone calls, flyers, site set up, etc.) o Number of adolescent postcard reminders mailed in 2011 o Number of adolescents vaccinated at registration clinics: ____ o 2011 Tdap rate to increase by 1% from 2010's 7th grade exclusion rates o 2011 HPV doses increased by 25 doses from 2010 o 2011 Meningococcal doses increased by 25 doses from 2010 o Eval of reminders and	To be completed for the CY 2011 Report	To be completed for the CY 2011 Report

	place and content of events o Send "Save the Date" flyers thru registration mailings o Provide pre- and day of event staffing o Host events @ Coffenberry, Jo Lane, Fremont, Winston, & Sutherlin middle schools. o Evaluate event success to modify future activities			events and modification for following years' events completed o Evaluation results___		

FAMILY PLANNING PROGRAM ANNUAL PLAN
FOR FY '12
July 1, 2011 to June 30, 2012

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

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

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

Goal 3: To promote awareness and access to Emergency Contraception among Oregonians at risk for unintended pregnancy.

Goal 4: To direct services to address disparities among Oregon's high priority and underserved populations, including Hispanics, limited English proficient (LEP), Native Americans, African Americans, Asian Americans, rural communities, men, uninsured and persons with disabilities.

The format to use for submitting the annual plan is provided below. Please include the following four components in addressing these goals:

1. **Problem Statement** – For each of two chosen goals, briefly describe the current situation in your county that will be addressed by that particular goal. The data provided may be helpful with this.
2. **Objective(s)** – Write one or more objectives for each goal. The objective(s) should be realistic for the resources you have available and measurable in some way. An objective checklist has been provided for your reference.
3. **Planned Activities** – Briefly describe one or more activities you plan to conduct in order to achieve your objective(s).
4. **Evaluation** – Briefly describe how you will evaluate the success of your activities and objectives, including data collection and sources.

This document is being forwarded electronically to each Family Planning Coordinator so that it can be completed and returned via file attachment. Specific agency data will also be included to help with local agency planning. If you have any questions, please contact Carol Elliot (971 673-0362) or Cheryl Connell (541 265-2248 x443).

FAMILY PLANNING PROGRAM ANNUAL PLAN FOR
COUNTY PUBLIC HEALTH DEPARTMENT
FY 2012
July 1, 2011 to June 30, 2012

Agency: __**Douglas**_ **Contact:** __**Dawnelle Marshall, RN. BSN**____

Goal #__1_

Problem Statement	Objective(s)	Planned Activities	Evaluation
Changes in reimbursement and county general fund have led to challenges in providing services at all locations in Douglas County.	1. To maintain the ongoing provision of both drop in and annual exam visits in outlying offices. This would be drop in clinic 1x/wk and 1-2x/month for exams in the outlying offices.	1. Maintain outlying clinic operations at: -Canyonville- Every Thursday -Drain – Every Friday -Reedsport – Every Tuesday -Roseburg – M-F	Measure number of clients served at each clinic location/month.

Goal #__2__

Problem Statement	Objective(s)	Planned Activities	Evaluation
Changes in funding and resources had led to challenges in maintaining a broad range of birth control methods.	1. Maintain current available methods of birth control	a. Update pricing on quarterly schedule b. Update costing by 8/2012 c. Continue with referrals for Implanon	1. Completion of pricing changes and implementation of new pricing. 2. Completion of costing methodology by 8/2010. 3. Implementation of updated fees.

Objectives checklist:

x Does the objective relate to the goal and needs assessment findings?
X Is the objective clear in terms of what, how, when and where the situation will be changed?
X Are the targets measurable?
X Is the objective feasible within the stated time frame and appropriately limited in scope?

Progress on Goals / Activities for FY 10

(Currently in Progress)

The annual plan that was submitted for your agency last year is included in this mailing. Please review it and report on progress meeting your objectives so far this FY.

Goal / Objective	Progress on Activities
Changes in reimbursement and county general fund have led to challenges in providing services at all locations in Douglas County	Douglas County has been able to maintain a Family Planning clinic in each of the outlying facilities of Canyonville, Drain and Reedsport. In FY 2011/2012 the county has directed that PH cut the county general fund by 35%. This will mean the division will need to evaluated frequency of outlying clinic operations. In FY 09/10, clients served in: Canyonville: 250 Drain: 122 Reedsport: 147 Roseburg: 2310
Changes in funding and resources had led to challenges in maintaining a broad range of birth control methods	Current methods have been maintained, and pricing is updated quarterly. Due multiple priorities with on line EMR, costing has been delayed until the spring/summer of 2011 Ongoing method pricing is adjusted quarterly based on most current available costs of a particular method. .

Progress on Title X Expansion Funds:

Also, a reminder that supplemental "expansion funds" were awarded as part of your agency's regular Title X grant again this year. These funds were awarded for the purpose of increasing the number of new, low-income clients by expanding the availability of clinical family planning services. Please report any progress on the use of these funds for the following purposes:

□ Increase the range of contraceptive methods on your formulary and/or the available number of high-end methods (IUDs and Implanon) __The only high cost method that we do not provide at this time Implanon, but we provide referrals for those who are interested.

□ Increase the hours of your clinic(s), the number of staff available to see clients, the number of days services are available or offer walk-in appointments The hours of operation at most clinics has remained the same or scheduled based on demand for services. Douglas County has been able to maintain all drop in clinics for birth control services, and with the addition of a part time nurse practitioner has also had open appointment times on a walk in basis.

□ Add other related preventive health services, such as diagnosis and treatment of STIs _____ Douglas County operates STI clinic, so a lot of clients are seen in that clinic as well.

□ Other objective you identified specifically for your agency _____

EVALUATION OF WIC NUTRITION EDUCATION PLAN
FY 2010-2011

WIC Agency: Douglas County _____

Person Completing Form: Elizabeth Binkley, WIC Program Manager

Date: May 1, 2011 _____ Phone: (541) 440 – 3546 _____

Return this form, attached to email to: sara.e.sloan@state.or.us by May 1, 2011

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

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 online Participant Centered Education Module by July 31, 2010.

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

- Did your WIC Training Supervisor complete the module by December July 31, 2010?
- Was the completion date entered into TWIST?

Response:

- The WIC Training Supervisor was not able to complete the online Participant Centered module by July 31, 2010 due to staff turnover and the need to focus on other staff training, but completed it by September 12, 2010. Completion date was entered into TWIST.

Activity 2: WIC certifiers who participated in Oregon WIC Listens training 2008-2009 will pass the post test of the Participant Centered Education e-Learning Modules by December 31, 2010.

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

- Did all certifiers who participated in Oregon WIC Listens training 2008-2009 pass the post test of the Participant Centered Education e-Learning Modules by December 31, 2010?

Response:

- The certifier staff has not taken the post test of the Participant Centered Education eLearning Modules. Staff did a group in-service together to go through the PCE e-learning module on September 17, 2010, rather than just to do the post test. Staff has not yet completed the activities and observations. The plan is to have staff complete the activities, observations and post test by May 31, 2011.

Activity 3: Local agency staff will attend a regional Group Participant Centered training in the fall of 2010. The training will be especially valuable for WIC staff who lead group nutrition education activities.

Evaluation criteria: Please address the following question in your response.

- Which staff from your agency attended a regional Group Participant Centered Education in the fall of 2010?
- How have those staff used the information they received at the training?

Response:

- Staff who attended: Kathleen Baylor, Elizabeth Binkley, Judy Cheek and Aimee Wilhite.
- Staff has incorporated the PCE Group training information in the NE classes that they teach and have started revising some of the class outlines to include PCE skills.

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 December 31, 2010.

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:

- Our agency identified an assessment area of weakness to improve presenting infant behavioral cues to WIC mothers and how this relates to breastfeeding success. We were going to use the WIC specific materials on infant cues that were to be sent by State WIC but there has been a delay from the providing agency that was to have those materials, although staff has been using "Secrets of Baby Behavior" materials and utilizing the information with mothers.

- A strategy that was identified was to have a staff in-service to increase staff skills in providing infant behavioral cues counseling to parents.

Activity 2: Each local agency will implement components of the Prenatal Breastfeeding Class (currently in development by state staff) in their breastfeeding education activities by March 31, 2011.

No response needed. The Prenatal Breastfeeding Class is still in development.

Goal 3: Strengthen partnerships with organizations 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 strengthen partnerships with these organizations by offering opportunities for 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.

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

- Which community partners did your agency invite to attend the Group PCE training fall of 2010?
- How do you feel partnerships with those agencies were enhanced?
- What went well and what would you do differently?

Response:

- There were no community partners that were identified.

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 WIC Breastfeeding Module.

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

- Which community partners did your agency invite to attend a Breastfeeding Basics training and/or complete the online WIC Breastfeeding Module?
- How do you feel partnerships with those agencies were enhanced?
- What went well and what would you do differently?

Response only if you invited community partners to attend a Breastfeeding Basics training. The online WIC Breastfeeding Course is still in development.

- No response, did not invite community partners to attend.

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 June 30, 2011.

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

- Did/will the appropriate staff complete the new online Child Nutrition Module by June 30, 2011?
- Are the completion dates entered into TWIST?

Response:

- The State has extended the original completion date to July 31, 2011. The plan is to have the staff complete the new online Child Nutrition Module by July 31, 2011 and completion will be entered into TWIST.

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

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?

There were some changes to the original Staff In-service Plan. The 2nd Quarter was changed to a new in-service due to new risk criteria required training, the in-service for the 2nd Quarter was moved to the 3rd Quarter and the 3rd Quarter was moved to the 4th Quarter. The original 4th Quarter training on the new Child Nutrition module was postponed as described in Goal 4 Activity 1.

FY 2010-2011 WIC Staff In-services

In-Service Topic and Method of Training	Core Competencies Addressed	Desired Outcome
The PEC e-learning module. As a group the staff viewed the on-line module together. A day was set aside to do this.	This in-service addressed the 9 sections of the PCE e-learning module. It provided a review for staff who have had training in PCE and for the new staff to introduce them to PCE.	The desired outcome of this in-service is for staff to work toward the goal of completing the PCE e-learning module requirement and to review the PCE skills in providing counseling.
New Changes in WIC Risk Criteria: Risk 427.4, 131 and 133. The in-service guides sent from the State WIC Program were used.	This in-service provided information on the changes to risk criteria of the addition of Iodine as a risk for prenatal women and the Prenatal weight gain grids.	The desired outcome of this in-service is for staff to learn the new risk criteria, to assign the risks appropriately and to understand the reason for iodine supplementation, iodine sources and nutrition labels on foods.
Infant Feeding Cues. The staff watched the DVD from the State WIC Conference on the presentation by Jane Heinig.	This in-service is to review infant feeding cues and to increase staff knowledge on the importance of helping parents understand their infant's feeding cues.	The desired outcome of this in-service is for staff to increase their counseling skills in discussing infant feeding cues with parents.
State Review Tools. The State Review Tools were handed out and each section discussed that applied to expected staff	This in-service is to provide staff with the review tools used for the Local Agency State Review and to discuss the Compliance items that	The desired outcome is for staff to understand and follow WIC policy and procedure and meet the expectations of the Local

compliance.	are expected to be done at appointments and Quality Assurance items to work toward.	Agency State Review.

FY 2011 - 2012 WIC Nutrition Education Plan Form

County/Agency: Douglas County
Person Completing Form: Elizabeth Binkley, WIC Program Manager
Date: May 1, 2011
Phone Number: (541) 440 - 3546
Email Address: ehbinkle@co.douglas.or.us

Return this form electronically (attached to email) to: sara.e.sloan@state.or.us
by May 1, 2011
Sara Sloan, 971-673-0043

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

Year 2 Objective**:** During planning period, staff will incorporate participant centered education skills and strategies into group settings.

Activity 1: Local agency staff will attend a regional Group Participant Centered training focusing on content design to be held in the fall of 2011.

Note: Specific training logistics and registration information will be sent out prior to the trainings.

Implementation Plan and Timeline including possible staff who will attend a regional training:

Staff will be scheduled for the Group Participant Center training when State WIC provides the dates and registration information.

Possible staff to attend:
Kathleen Baylor
Elizabeth Binkley
Judy Cheek

Activity 2: Each agency will modify at least one nutrition education group lesson

plan from each category of core classes and at least one local agency staff in-service to include PCE skills and strategies by March 31, 2012. Specific PCE skills and strategies were presented during the PCE Groups trainings held in the Fall 2010 and Spring 2011.

Implementation Plan and Timeline:

The information presented at the Group Participant Education Trainings will be used to modify and update nutrition education group lesson plans. The core classes to be modified and completion timeline:

Infant feeding – birth to 12 months completion by September 2011
Feeding Toddler – 13 to 23 months completion by December 2011
Prenatal Nutrition completion by February 2012

Activity 3: Each agency will develop and implement a plan to familiarize all staff with the content and design of 2nd Nutrition Education options in order to assist participants in selecting the nutrition education experience that would best meet their needs.

Implementation Plan and Timeline:

An in-service will be planned by September 30, 2011 for WIC staff to learn to assist clients in selecting their 2nd nutrition education experience. As each core class is updated, all certifier and clerical staff will attend the practice presentations of the new modified PCE groups and give feedback.

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

Year 2 Objective: During planning period, each agency will incorporate participant centered skills and strategies into their group settings to enhance their breastfeeding education, promotion and support.

Activity 1: Each agency will modify at least one prenatal breastfeeding class to include PCE skills and strategies by March 31, 2012. Specific PCE skills and strategies were presented during the PCE Groups trainings held Fall 2010 and Spring 2011.

Implementation Plan and Timeline:

Using the information learned at the Participant Centered Education Group training the Prenatal Breastfeeding class will be modified to include PCE. To be completed by March 31, 2012.

Activity 2: Each agency's Breastfeeding Coordinator will work with the agency's Training Supervisor to provide an in-service to staff incorporating participant centered skills to support breastfeeding counseling.

Note: In-service content could include concepts from Biological Nurturing, Breastfeeding Peer Counseling Program – Group Prenatal Series Guide and/or Breastfeeding Basics – Grow and Glow Curriculum. An in-service outline and supporting resource materials developed by state WIC staff will be sent by July 1, 2011.

Implementation Plan and Timeline:

Using the State WIC developed training materials an in-service for staff on developing their Participant Centered Education skills to support breastfeeding will be presented by November 30, 2011.

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

Year 2 Objective**:** During planning period, each agency will continue to develop strategies to enhance partnerships with organizations in their community that serve WIC participants by offering opportunities to strengthen their nutrition and/or breastfeeding education.

Activity 1: Each agency will invite at last one partner that serves WIC participants and provides nutrition education to attend a regional Group Participant Centered Education training focusing on content design to be held fall of 2011.

Note: Specific training logistics and registration information will be sent out prior to the trainings.

Implementation Plan and Timeline:

Douglas County does not have any community partners who provide nutrition education to WIC participants, and does not have anyone to invite to the training.

Activity 2: Each agency will invite at least one community partner that provides breastfeeding education to WIC participants to attend a Breastfeeding Basics – Grow and Glow Training complete the Oregon WIC Breastfeeding Module and/or complete the new online Oregon WIC Breastfeeding Course.

Note: Specific Breastfeeding Basics - Grow and Glow training logistics and registration information will be sent out prior to the trainings. Information about accessing the online Breastfeeding Course will be sent out as soon as it is available

Implementation Plan and Timeline:

When the State WIC Program provides the information on the training logistics and registration, Mercy Medical Center Birth Place will be contacted and invited to participate.

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

Year 2 Objective: During planning period, each agency will continue to increase staff understanding of the factors influencing health outcomes.

Activity 1: Each agency will conduct a Health Outcomes staff in-service by March 31, 2012.

Note: An in-service outline and supporting resource materials developed by state WIC staff will be sent by July 1, 2011.

Implementation Plan and Timeline:

When State WIC provides the resource materials a Health Outcome staff in-service will be completed by February 28, 2012.

Activity 2: Local agency staff will complete the new online Postpartum Nutrition Course by March 31, 2012.

Implementation Plan and Timeline:

WIC staff will be scheduled time to work on the new Postpartum Nutrition Course, to be completed by March 31, 2012.

Activity 3: Identify your agency training supervisor(s) and projected staff quarterly in-

service training dates and topics for FY 2011-2012. Complete and return Attachment A by May 1, 2011.

Agency Training Supervisor(s): **Elizabeth Binkley, MS, R.D.**

Attachment A

FY 2011-2012 WIC Nutrition Education Plan

WIC Staff Training Plan – 7/1/2011 through 6/30/2012

Agency: **Douglas County**

Training Supervisor(s) and Credentials: **Elizabeth Binkley, MS, R.D.**

Staff Development Planned

Based on planned program initiatives, your program goals, or identified staff needs, what quarterly in-services and or continuing education are planned for existing staff? List the in-services and an objective for quarterly in-services that you plan for July 1, 2011 – June 30, 2012. State provided in-services, trainings and meetings can be included as appropriate.

Quarter	Month	In-Service Topic	In-Service Objective
1	September	WIC Participant Selection of their 2nd Nutrition Education Experience	To help staff understand how to assist WIC participants in selecting the 2nd NE options to best meet their needs.
2	November	PCE Breastfeeding Support	To help staff develop PCE skills in breastfeeding counseling.
3	February	Factors that Influence Health Outcomes	To increase staff understanding of the factors influencing health outcomes and to learn how to share that information with WIC participants.
4	March	Review of the PCE Goals for the FY 11/12 and the new Postpartum Nutrition Course	To review with staff the PCE Goals that have been the focus of the FY11/12 NE Plan and discuss what they have learned in the Postpartum Nutrition Course.