



LINCOLN COUNTY

PUBLIC HEALTH

ANNUAL PLAN

May, 2011

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

**Local Public Health Authority/Board of Health
Chair, Lincoln County Commission**

**Lincoln County
County**

**May 25th, 2011
Date**



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EXECUTIVE SUMMARY

This is the required Annual Public Health Report for the Lincoln County Public Health Division of Lincoln County Health and Human Services.

The requirement for an Annual Plan is in statute (ORS 431.375–431.385 and ORS 431.416) and rule (OAR Chapter 333, Division 14). OAR 333-014-0060(2)(a) refers to CLHO Standards program indicators as part of the Annual Plan. Statute requires the plan submission on May 1. Locally, it has been the tradition for the Board of Health/Board of County Commissioners to approve the Annual Plan at the end of May following county budget hearings. Permission has been requested and granted by the state to submit the Lincoln County Annual Plan by June 1st, 2011. The Annual Plan is an opportunity for the LPHA (Local Public Health Authority) to describe for both the state public health agency and the local community the goals and strategies to fulfill statutory, contractual, and locally driven obligations. The local dialogue and the discussion with the state are important aspects of the Annual Plan process. The Oregon Health Authority (OHA) is required to approve or disapprove the Annual Plan.

A copy of ORS Chapter 431 can be found at <http://www.leg.state.or.us/ors/431.html>

A copy of OAR Chapter 333 Division 14 can be found at http://arcweb.sos.state.or.us/rules/OARs_300/OAR_333/333_014.html.

A copy of the Minimum Standards for Local Health Departments can be found at

<http://public.health.oregon.gov/ProviderPartnerResources/LocalHealthDepartmentResources/Pages/reference.aspx>

Lincoln County Health and Human Services adequately provides the five basic services contained in statute (ORS 431.416) and rule (OAR Chapter 333, Division 14). These include: Epidemiology and Control of Preventable Diseases; Parent and Child Health Services including Family Planning; Environmental Health Services; Collection and Reporting of Health Statistics; and Health Information and Referral.

In addition, many services described in ORS 333-014-0050 are provided including public health emergency preparedness, health promotion including tobacco prevention and education and chronic disease management, as well as direct provision of all childhood and adult immunizations (with the exception of vaccines required for foreign travel).

Lincoln County PH Division experienced a comprehensive examination of all public health programs during the “Triennial Review” process in February and March of 2011. The results of that review are scheduled to be shared with the Public Health Advisory Committee and a representative from the County Board of Health/County Commissioners on May 3rd, 2011. There were both commendations for the work the agency is doing and compliance findings which will require corrective action by administration and staff.

Lincoln County PH has benefitted greatly during FY 2010-11 from the services of an Americorps VISTA; this position has been shared in a novel regional collaboration with Benton County. The work of this Americorps VISTA has focused on assisting PH Division staff in gathering the required documentation and preparing to apply for Public Health Accreditation when the application process and national standards are finalized in the fall/winter of 2011/12.

Regional and local health initiatives to benefit Lincoln County residents have taken shape during FY 2010-11; public health is excited to be in leadership and partnering roles as it supports community members in taking responsibility for health-related projects.

The PH Division Director has participated as a “Key Leader” in the formation of a regional project entitled the Coast to Cascades Wellness Network in cooperation with Linn and Benton County PH, the Samaritan Hospital system, OHSU Office of Rural Health and the regional Council of Governments. The Vision Statement of the group is as follows:

“The Coast to the Cascades Community Wellness Network leads and sustains a system of partnerships of agencies and organizations working together to provide integrated services and programs to promote individual and community health.”

Prompted by the receipt of a one year planning grant with a focus of Childhood Obesity, the Coast to Cascades Wellness Network has gone on to apply for continuation funding from the CDC and is moving forward to examine and take action on a number of other health issues in addition to Childhood Obesity.

Locally, the PH Division Director is currently the Chair of the Local Childhood Obesity Partnership; this local group is a direct extension of the previously mentioned Coast to Cascades Wellness Network. The Mission Statement of the local organization is:

“To enhance the health of children and their families through the delivery of evidence-based and/or innovative community health promotion services targeting obesity”.

Meeting monthly since the summer of 2010 and staffed by a CHIP (Community Health Improvement Partnership) project coordinator, the group has developed prioritized objectives in the areas of Health Care, Schools, and Community/Family. With support from staff, a grant has been obtained to purchase biometric measuring devices and conducted health screenings at one elementary school, one middle school, and one high school in Lincoln County so that we can begin to obtain local data regarding the prevalence of local childhood obesity and establish a baseline for annual measurements in coming school years to evaluate effectiveness of interventions. The Lincoln County Childhood Obesity Partnership has also taken an active role in reviewing and offering recommendations to the Lincoln County School District Wellness Policy, compiled an analysis of health-related curriculum and physical activity opportunities for each school in the Lincoln County School District, received presentations from OR Ext. Service Master Gardeners regarding existing and planned community gardens, and participated in projects related to hunger and healthy food (Lincoln County FEAST, school backpack programs, subsidized feeding programs in schools and other community settings, Pick of the Month demonstrations in schools and food banks, etc).

An additional community effort in response to need is the formation of a Lincoln County Dental Task Force which held its first meeting in April of 2010. Access to dental care for low income and Medicaid/un-insured populations in Lincoln County has been a long term challenge. Multiple community organizations were raising funds and sponsoring dental van visits to the county, but there has been no central coordination or publicity for those dental van visits. Preventative services (fluoride varnish and sealants) have been very limited; contributing to higher rates of decay in children. There is no fluoridation in municipal water supplies. The local Dental Task Force is optimistic that committed individuals and agencies can effectively impact these issues and increase the attention on oral health as an integral part of overall health status of Lincoln County residents.

Our local Tobacco Action Coalition celebrated a one year anniversary in January of 2010. With a roster of 27 community members, businesses, non-profit organizations, and health professionals this group is actively working to be informed and take action in our communities to impact our high county tobacco use rate.

The Local Public Health Advisory Committee (PHAC) is very committed to its role of guiding Lincoln County Health and Human Services on issues related to the advancement of local public health activities. In the monthly

meetings of our PHAC during the past year, members have received information and participated in discussion regarding a variety of public health activities and programs. Many of our PHAC members have contributed volunteer effort and time in assisting with our CHANGE (Community Health Assessment and Group Evaluation) Assessment required of our Healthy Communities Grant.

Internally, our Maternal Child Health Home Visiting Program RNs have demonstrated leadership in the development of their professional knowledge regarding OMAHA documentation. OMAHA is an internationally recognized nursing language that is specifically suited to home visiting and field nursing functions. It is comprised of a problem rating scale for outcomes which evaluates knowledge (what the client knows), behavior (what the client does) and status (how the client is). Lincoln County was proud to host a well-known subject matter expert on OMAHA for an OMAHA Basics workshop here in September of 2010, as well as participate in a special Conference of Local Health Officials (CLHO) state Information Management presentation in Newport on the following day. Based on funding generated via home visiting services, the department purchased a web-based specialized electronic documentation program in the fall of 2010 (CHAMPS/Nightingale Notes), and are now completing the training for implementation of that software. CHAMPS/Nightingale Notes uses the OMAHA nursing language and will more effectively capture the outcomes of RN Home Visitation efforts; it has the added benefit of helping this part of our overall business operation achieve the goals of “paperless” charting. Eventually (based on wireless internet connectivity), home visiting RNs will be able to chart via laptops or tablet computers during and immediately following their visits in much less time, which will increase their productivity.

The entire Lincoln County Public Health Division was budgeted with 23.69 FTE for fiscal year 2010-11. These trained and dedicated staff members deliver all public health services under the supervision of a PH Division Director, three Program Managers, fiscal support and clerical services. The department has an approved budget of \$4,014,382 and amended budget of \$4,074,773 for FY 2010-11. The Public Health Division budget is a subset of the larger Lincoln County Health and Human Services budget; the amended amount for all combined divisions of HHS (including Mental Health/Drug and Alcohol/DD and Primary Care/SBHC) is \$14,767,711.

FY 2011 will bring a significant leadership transition in Lincoln County Health and Human Services. Director Paula Sampson will retire in late summer and active recruitment for her position is underway. Ms. Sampson has been employed by Lincoln County HHS for 36+ years, and has served since January of 2009 as the HHS Director. She was instrumental earlier in her career in the establishment of School Based Health Centers....we now have four centers located in four high schools in different geographic areas of the county, as well as a sizeable Federally Qualified Health Center operation with two additional locations, all under the umbrella of a Primary Care Division Director. Although the organization is sad to see her retire, she has positioned the entire organization to be forward thinking and financially stable for the future. There is currently a strong internal leadership team in place to support a new HHS Director going forward.



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ASSESSMENT

A. LINCOLN COUNTY DEMOGRAPHICS

Lincoln County is located on the central Pacific Oregon coastline, has a land mass of 992 square miles and a total population of 46,293 (US Census Quick Facts 2009 estimate). It lacks a major metropolitan area and consists of many small communities scattered throughout the geographic region. Newport, the largest town and county seat, has a population of 9,740. Lincoln City is the next largest with 7,420. Other population centers/municipalities include Depoe Bay, South Beach, Seal Rock, Waldport, and Yachats. 38% of the population lives in rural unincorporated areas. This rural geography often isolates families. Isolation is compounded by a limited public transportation system as well as increasing costs of gasoline.

Traditionally, Lincoln County residents have relied on a resource-based economy involving commercial fisheries and logging. Those resources have had measurable declines over time, causing economic challenges for wage-earners whose skill sets without re-training and further education are not a good fit for other employment. Emerging to replace resource-based employment has been an increasing dependence on the tourism industry; these jobs are noted to be low-paying and experience extremes in seasonal fluctuation and earnings. The unemployment rate in Lincoln County was 11.4% in December of 2010.

The economic challenges of Lincoln County are particularly difficult for young families and children. There are 5,186 students enrolled in the Lincoln County School District and an additional 327 students enrolled in 3 locations of Head Start service delivery. Oregon Dept. of Education data shows a district-wide average of 66% of students eligible for free and reduced lunch for school year 2009-10. This level of need ranked 5th highest of all school districts in Oregon for that school year. In addition, we see disparities within the district, with 6 of our schools having between 70% and 85% of their students meeting free and reduced lunch requirements.

Census data shows median household income for Lincoln County residents for 2008 at \$39,534 or \$10,631 below the rest of Oregon. An estimated 16.7% of Lincoln County residents live below the FPL, compared to 13.5% in the rest of our state. An estimated 26% of our children live in poverty.

Lincoln County has not had a past history of ethnic or racial diversity, but increased dependence on tourism has been accompanied by an increase in the local Hispanic population; 2009 Census data estimates 7.9% or county residents are persons of Hispanic or Latino origin. This figure reflects a sharp increase from the 4.6% Hispanic population presence in 2000. We also have seen increased enrollment of Hispanic children in Head Start settings in the county (49% of all Head Start children) and in our local WIC program (19% of all enrolled).

Lincoln County has seen significant recent increases in reports of child abuse. For FFY 2010 in our county there were 362 assessments related to child abuse with 108 of those determined to be “founded”. Our DHS partners report that a higher percentage of reports are actually “founded” in Lincoln County than in other parts of our region....indicating that the calls and reports are determined to be true and that a child is in danger. Lincoln County has an average of 120 children at any point in time in foster care due to parental abuse or neglect.

The County Health Rankings of 2011 report Lincoln County to be in the bottom ten counties in Oregon in both Health Outcomes and Health Factors. Health Outcomes examine mortality (how long people live) and morbidity (how healthy people feel). Lincoln County ranked at 27th in Health Outcomes (of 33 ranked Oregon counties). Health Factors considers health behaviors, clinical care, social and economic data and contributing environmental issues relative to health. Lincoln County ranked 25th in Health Factors (of the same 33 ranked Oregon counties). Residents of Lincoln County die at younger ages for a variety of reasons, but our very high county tobacco use rate (28%) is a major contributor to the incidence of chronic disease

and early death. The County Health Rankings will be addressed in further detail later in this assessment portion.

In the *State of Oregon Summary of Needs Assessment for Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program* dated March 21st, 2011, Lincoln County demonstrates increased risk in 7 of 11 of the federally required risk factors identified as part of the selection process for funding for evidence based home visiting programs. These risk factors for Lincoln County are summarized in the table below:

Indicator	Lincoln County	OR State
Low Birth Weight (LBW) Infants (2009)	6.7%	6.2%
Infant Mortality	6.4	5.2
Poverty	16.7%	13.5%
# of crime arrests ages 0-19/1,000 juveniles ages 0-19	18.0	14.7
Domestic Violence	9.8%	5.0%
% of High School Drop-outs grades 9-12	5.0%	3.4%
Child victim rate per 1,000 children	23.2	12.5%

Lincoln County Demographics are as follows:

Age	Lincoln County	Oregon State
0 – 4	2,173 – 4.9%	223,005 – 6.5%
5 – 9	2,461 – 5.5%	234,474 – 6.9%
10 – 14	2,966 – 6.7%	242,098 – 7.1%
15 – 19	2,922 – 6.6%	244,427 – 7.1%
20 – 24	1,917 – 4.3%	230,406 – 6.7%
25 – 34	4,193 – 9.4%	470,695 – 13.8%
35 – 44	6,251 – 14.1%	526,574 – 15.4%
45 – 54	7,450 – 16.7%	507,155 – 14.8%
55 – 59	2,871 – 6.5%	173,008 – 5.1%
60 – 64	2,589 – 5.8%	131,380 – 3.8%
65 – 74	4,759 – 10.7%	219,342 – 6.4%
75 – 84	3,073 – 6.9%	161,404 – 4.7%
85 and older	854 – 1.9%	57,431 – 1.7%
Total	44,479	3,421,399

Racial and Ethnic Group	Percentage of County (Census Quick Facts 2009 Estimate)
White	91.4
Native American/Alaska Native	3.8
Asian	1.2
Hispanic/Latino	7.9
Over age 65	20.2% (State average is 13.5%)

B. Assessment Data based on the County Health Rankings

The 2nd year of the national County Health Ranking project has afforded Lincoln County the availability of assessment data that can be shared in this plan as well as shared broadly in the community. Funded by the Robert Wood Johnson Foundation, the County Health Rankings gives counties comparative information based on available state and local data from a variety of credible sources. The 2nd report was released in March of 2011. The project has been funded for 3 years; new reports will be published annually during that time. There are limitations to the data in some areas of the report; data may span multiple years to reach statistically valid local sample size and may “lag” behind (not fully reflecting community efforts that have been directed at improvements). Despite these limitations, the County Health Ranking is the most comprehensive report ever made available for local use which examines the health of Lincoln County residents. Enhancements in the national website have occurred in the past year which will allow public health professionals as well as members of the general public to easily locate and research effective evidence-based interventions for the challenges identified in the County Health Rankings data.

Lincoln County Health and Human Services employs no staff with epidemiological or statistical expertise. We have chosen to rely on the County Health Rankings data provided for us in the assessment portion of our Annual Plan for 2010-11 and will continue to do so as long as such data remains available.

Lincoln County ranked in the bottom 1/3 of the state of Oregon in both Health Outcomes and Health Factors scoring in the 2011 report. It can be said that the measures reflected in the Health Factors areas are predictive of the final Health Outcomes ranking. The determinants of health represented a complex and interactive equation; much of “health” occurs outside of a clinical setting.

Lincoln County Health Outcomes Ranking: 27th of 33 counties in Oregon
Lincoln County Health Factors Ranking: 25th of 33 counties in Oregon

Health Outcomes

Mortality and Morbidity:

Lincoln County Ranking: 27th of 33 Counties

Mortality is a measure of premature death or years of life lost prior to the age of 75. Lincoln County residents die at younger ages from a variety of causes. Accidental deaths, suicides, motor vehicle death rates, cardiovascular disease and stroke, and cancer all contribute to the higher early death rate of local residents. Underlying many of these causes of early death is the data related to the county tobacco use rate (to be discussed in another section of the report).

Morbidity contributors include BRFSS data related to self reported fair or poor health, poor physical health days and poor mental health days. 18% of Lincoln County residents surveyed reported themselves to be in fair or poor health. This compares to a national benchmark of 10% and a state-wide percentage of 14%. 3.9% of Lincoln County residents report having poor mental health days compared to 3.3% of state residents.

Morbidity data also included an examination of the percentage of low birth weight babies born to county residents between 2000 and 2007. 5.2% of Lincoln County live births during that time period were

considered to be LBW (low birth weight); this is actually below the national benchmark and OR State percentage of 6%.

Health Factors:

Lincoln County Ranking: 25th of 33 Counties

The County Health Ranking Project used a combination of weighted measures (as reflected below) to reach the Health Factors ranking for each county.

Health Behaviors: 30% of Health Factor Ranking

Clinical Care: 20% of Health Factor Ranking

Social and Economic Factors: 40% of Health Factor Ranking

Physical Environment: 10% of Health Factor Ranking

As we focus on the Lincoln County data for each of the 4 weighted areas, we see the following:

Individual Health Behaviors:

Lincoln County Ranking: 28th of 33 counties

Tobacco Use:

- Adult Smoking Rates: **27 % of Lincoln County adults are smokers.** 9,822 Lincoln County residents smoke on a daily basis. The rate of smoking by Lincoln County residents is higher than 34 of 36 other Oregon counties....exceeded only by Coos and Douglas County residents. The overall smoking rate for Oregon state residents of 18%. In a closer look at neighboring counties, Benton County's rate is 12%, Polk County's rate is 16%, Lane County is at 19% and Tillamook County at 20%. Smoking patterns are predictive of increased rates of future disease and early death. Smokers die an average of 14 years earlier than non-smokers.
- Tobacco Use During Pregnancy: 2008 Birth Certificate Data shows that of the 471 live births to county residents in that year, 132 women or 28.2% of women who delivered live infants report smoking while pregnant. Lincoln County ranked 3rd in the state for 2008 in the number of women smoking during their pregnancies (with Baker and Douglas counties showing higher rates). Smoking during pregnancy is positively correlated to the delivery of smaller birth weight infants.
- 8th Grade Smoking Rates: 2008 Lincoln County Oregon Healthy Teens data showed 9.2% of 8th grade students reported cigarette use in the previous 30 days. This is an increase of 1.2% over the preceding year. 19.3% of these same 8th graders reported that they had (sometime in the past) smoked a whole cigarette with some reporting that happening at 8 years of age or earlier.
- 8th Grade Snuff/Chew Rates: 2008 data also reveals that 3.6% of 8th grade students reporting use of chewing tobacco or snuff in the previous 30 days.
- 11th Grade Smoking Rates: 2008 Lincoln County Oregon Healthy Teens data showed that 20.8% of 11th grade students reported cigarette use in the previous 30 days. This pattern reflects a slight decrease (1.2% lower) from 2007 data.

- 11th Grade Snuff/Chew Rates: 9.9% of 11th grade students reported use of chewing tobacco or snuff in the previous 30 days.
- An estimated 30% of all Lincoln County deaths are related to tobacco use. Smoking patterns are predictive of future diseases and early death.

Adult Obesity:

- The definition of obesity is an individual that has a BMI (Body Mass Index) which exceeds 30kg/m². BRFSS data from 2004-2007 show that 26% of Lincoln County residents meet this definition of obesity; by comparison, the Lincoln County level of obesity is slightly higher than the national benchmark and the OR State level of 25%.
- In addition to those individuals in the county population who have been classified as obese, it is important to examine those additional individuals who meet the definition of overweight; BMI (Body Mass Index) at 25-29.9 kg/m². An additional 37% of Lincoln County residents are estimated to meet this lower standard, compared to 36.3% of state residents.
- When overweight and obesity data are added together to represent risks in Lincoln County residents, we see that 63% of Lincoln County residents are either overweight or obese. This represents nearly 2/3 of all county residents.
- Generally, BRFSS data is considered highly reliable. However, one recent study has shown that height and weight obtained via BRFSS telephone survey questions may underestimate weight when compared to actual measurement....the implication of this information is that the rates of obesity and overweight may be underreported in the Lincoln County data obtained via BRFSS.

Alcohol Use:

The County Health Ranking project attempted to capture the prevalence of excessive alcohol use by the use of two indicators; binge drinking is defined as five or more drinks at one time by a man or four or more drinks at one time by a woman and heavy drinking as defined drinking more than 1 (for women) or 2 (for men) drinks per day on average. Excessive drinking is a risk factor for a number of adverse health outcomes including alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, inter-personal violence and motor vehicle accidents.

Data related to binge drinking for the Lincoln County level County Health Ranking Report came from BRFSS questions. The question posed by BRFSS researchers was “Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 or more drinks on one occasion?” For determination of overall use, individuals were asked if they had consumed any alcoholic beverage in the last 30 days and for heavy use, males were asked if they consumed 2 or more alcoholic beverages during each day for the last 30 days (women = 1 or more daily for the same time period).

- 19% of Lincoln County residents are considered to be “excessive drinkers” by self-admission of consumption patterns according to BRFSS data. Only 3 counties in Oregon report a higher percentage of “excessive drinkers” (Multnomah at 20%, Tillamook at 21%, and Wallowa at 24%)
- Oregon Healthy Teen Data from 2008 provide information on the level of alcohol use by 8th and 11th graders. In 8th graders, 45.7% of them reported having consumed at least one drink of alcohol in the last 30 days. We see a lower rate of 30 day alcohol consumption in older teens in the 11th grade data from 2008; only 24.6% of them report using alcohol in the preceding month. It is important to remember that early initiation of substance use (including alcohol) is strongly correlated to young adult and adult dependency and addiction issues. Some teens in both the 8th and 11th grade tell us that their first use of alcohol (more than a sip or two) occurred at age 8 or younger.
- Binge drinking patterns in youth in Lincoln County also are concerning. Again, taken from OR Healthy Teen 2008 data, 10% of 8th graders and 29% of 11th graders report having consumed 5 or more drinks in a row or within a couple of hours in the last 30 days. The 11th grade data from Lincoln County teens on binge drinking rates exceeds the binge drinking rates from the adult male population in the county.
- Alcohol related motor vehicle crashes make up a significant proportion of alcohol-related deaths. A driver with a blood alcohol concentration of 100 mg/dL or higher is 7 times more likely to be involved in a fatal motor vehicle crash and a driver with a blood alcohol concentration of 150 mg/dL or higher is 25 times more likely to be involved in a fatal crash when compared with a driver who has consumed no alcohol.
- The data used in the County Health Ranking report to determine the Death Rate from Motor Vehicle Accidents came from the National Vital Statistics System (NVSS) at the Centers for Disease Control. Motor vehicle crash deaths are reported as the crude mortality rate per 100,000 population due to on or off road accidents involving a motor vehicle.
- In the time period between 2001 and 2007 the motor vehicle fatality rate for Lincoln County is 19/100,000. The comparable rate for the rest of Oregon is 14/100,000. The national benchmark for this measure is 12/100,000.

Unsafe Sex

The County Health Ranking intent is to reflect sexual behavior that increases adverse outcomes such as unintended pregnancy and transmission of sexually transmitted infections. Data regarding failure to use contraception or condoms are difficult to gather at the county level; therefore two proxy measures were used for this factor of the Health Factor Ranking.

Teen pregnancy increases the risk for repeat pregnancy and for contracting a sexually transmitted disease. It is associated with poor prenatal care and pre-term delivery. These physical impacts on the teen and her infant are in addition to the common adverse long-term consequences of teen parenting (including lower levels of educational attainment, higher rates of relationship instability, unemployment, and welfare dependence).

Sexually transmitted infections represent a burden not only with those impacted by the disease, but on the community as a whole. Chlamydia is the most common bacterial sexually transmitted infection in North America and is a major cause of tubal infertility, ectopic pregnancy, pelvic inflammatory disease and chronic pelvic pain. Chlamydia can be easily transmitted in casual sexual encounters, with development of symptoms coming in a delayed fashion, making it a difficult disease to treat in all individuals involved in sexual encounters and their multiple sexual partners.

- The Birth Rate per 1,000 female population from the ages of 15-19 between the years of 2001-2007 showed that Lincoln County had 369 teen births for a teen birth rate of 39/1,000 population. The Oregon rate for this measure for the same time period was 36/1,000 and the National Benchmark is 22/1,000.
- Lincoln County had a Chlamydia rate in 1998 of 198 cases/100,000 population of this sexually transmitted disease. 2009 data shows 78 cases or a rate of 169.8/100,000 population. This is an encouraging trend for public health which needs to continued to be monitored.

Clinical Care (20% of the Health Factor Ranking)

Lincoln County Ranking: 16 of 33 Oregon Counties

Access to Care

There are multiple issues involved in an individual being able to obtain necessary care when well or sick. Access to care speaks to having coverage for care (insurance or a public payer option), a provider who is willing to accept the specific coverage, close proximity of a care provider to home/work/school setting, and the availability of an appointment in a reasonable time frame with that care provider. Barriers to access to care include coverage issues (insurance which is major medical only or has high co-pays or deductibles), lack of transportation to or distance from a primary care provider office setting, low levels of health literacy to make decisions about seeking care or complying with care recommendations, or long waits for appointments.

Having access to care requires not only having financial coverage but also access to providers. While high rates of specialist providers has been shown to be associated with higher, and perhaps unnecessary, utilization, having sufficient availability of primary care providers is essential so that people can get preventive and primary care, and when needed, referrals to appropriate specialty care.

The first measure used for this category by the County Health Rankings was the number of individuals under the age of 65 with no health insurance. The data for this measure come from the Census Bureau's Small Area Health Insurance Estimates. The second measure used is the ratio of primary care providers to the number of county residents. The data on primary care providers were obtained from the Health Resources and Services Administration's Area Resource File (ARF) for 2009. The ARF data on practicing physicians come from the AMA Master File (2008).

- The Census Bureau's Small Area Health Insurance Estimate for Lincoln County for 2007 calculated that there were 7,698 individuals or 21% of county residents under the age of 65 years who had no medical insurance. This compares unfavorably to the national benchmark of 13% and is equal to the percentage of OR residents on the whole.

- The ratio of population to primary care providers is Data about Lincoln County from 2008 used in the County Health Rankings showed a ratio of 1,125:1 compared to the rest of Oregon at 739:1 and the national benchmark of 631:1.

Quality of Care

Quality of care can be defined as the right level of care for the right person at the right time. The Institute of Medicine (IOM) further defines the quality of health care as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”. IOM goes on to list six characteristics of quality care: Safe, timely, effective, efficient, equitable, and patient centered.

The County Health Ranking project used three measures to focus on the quality of care in Lincoln County. All three data sets focused on data available from Medicare enrollees. The first of these was hospitalizations for ambulatory care sensitive conditions that could have been managed without hospitalization. The second measurement relates to rates of regular HbA1c levels among diabetics as a reflection of long term management of the disease by the patient and the primary care provider. Finally, the percent of chronically ill individuals that received hospice care in the last 6 months of life was used based on evidence that suggests that terminally ill patients have a higher quality of life during their last months if hospice care is involved. All three measures in the Quality of Care category are derived from the Dartmouth Atlas, a project that utilizes Medicare claims data from around the United States.

Lincoln County ranked 46/100,000 Medicare enrollees in preventable hospital stays (compared with Oregon also at 46/100,000 Medicare enrollees and the national benchmark at 52/100,000 Medicare enrollees). Our local primary care providers are doing a good job with diabetic (86% of diabetic Medicare enrollees receiving HbA1c levels) and mammography (67% of Medicare enrollees) screening.

Social and Economic Factors

Lincoln County Ranking: 25th of 33 Counties

Education

Health and education levels are linked in multiple ways: Education often results in higher income and better job opportunities, particularly for jobs which provide a comprehensive package of medical benefits. Increasing levels of education are positively correlated with health literacy or the ability to understand and take action on health information. More education also has been shown to increase an individual’s sense of personal control, which lowers the risk for chronic disease and personal impairment.

County Health Rankings looked at two measures of education in the Lincoln County population.

- High School Graduation is defined as the percent of the ninth grade cohort that graduates from high school in a normal four year time span. For the 2011 Rankings, estimates were based on the restricted-use versions of the LEA Universe Survey Dropout and Completion data and the Public Elementary/Secondary School Universe Survey data. These data were requested from NCES for the school year 2006-2007. This data set shows that 75% of Lincoln County teens graduate from high school in a timely fashion. This compares to the rate of 74% across Oregon; both Lincoln County and Oregon teens fail to meet the national benchmark of 92%.

- Lincoln County residents older than high school age have a history of low educational attainment. The 2005-2009 American Community Survey 5-Year Estimates show that only 43.4% of Lincoln County adults ages 18-24 years have a High School Diploma or GED, and only 28.9% of those 25 years and older have reached that same standard.
- 53.3% of county residents ages 25-44 have some college education; this is nearly 10% below the Oregon state level of 64%.
- Higher education aspirations and attainment follow familial patterns; if a parent has a low level of educational attainment it may be more challenging for children in that family to see the value of higher levels of education or successfully navigate the steps necessary to be eligible to successfully apply for college admission, identify financial support for college education, and be academically successful in a collegiate setting.
- Higher levels of education have been linked to individuals feeling empowered and informed to make better individual health choices. Conversely, lower levels of education are commonly associated with higher levels of tobacco use, higher levels of drug and alcohol use, and higher rates of obesity. It is in the best interest of a population to promote increasing levels of education not only for the individual and community economic benefits, but for the individual and community's health status.

Employment

Unemployment data reveals the overall economic situation of the community and provides information about the percentage of the population that may be at risk for health concerns secondary to unemployment. With the loss of a job comes the loss of insurance coverage and/or the loss of income to pay for necessary health care. Data for the County Health Ranking report came from the Bureau of Labor Statistics Local Area Unemployment information (LAUS) for 2009 and includes individuals age 16 and older.

- The LAUS information for Lincoln County shows an unemployment rate of 10.4%. This represents the percentage of Lincoln County residents ages 16 and older actively seeking employment.

Children in Poverty

Documenting the poverty within a community can provide important information about the ability of a percentage of the population to meet basic needs. Children in poverty face greater consequences and health risks than adults. Poverty may also be related to lower levels of educational aspiration and achievement, thereby decreasing the opportunity for employment that would help to break the poverty cycle.

Children in poverty is the percent of children under age 18 living below the Federal Poverty Line (FPL) Children in poverty estimates used in the County Health Rankings are provided by the Small Area Income and Poverty Estimates (SAIPE) program through the U.S. Census and were taken from 2008 data.

- 26% of Lincoln County children live in households that are below the Federal Poverty Level. Only 3 other counties in Oregon have more children in poverty than we do in Lincoln County. The percentage of children in poverty in Oregon is 18%. The current FPL for a family of 4 is \$22,350.
- As previously mentioned, the level of poverty in Lincoln County is linked to hunger and food insufficiency reflected in free and reduced lunch rates in the Lincoln County School District. "Backpack" programs which allow children to receive a food supply for weekends and school

holidays are operated by volunteers or are under consideration in every area of the county, as are summer feeding programs when school is not in session. Hunger is an every-day experience for many of our children.

Family and Social Support

Poor family support, minimal contact with others, and limited involvement in community life are associated with increased morbidity and early mortality. Furthermore social support networks have been identified as powerful predictors of health behaviors, suggesting that individuals without a strong social network are less likely to participate in healthy lifestyle choices.

The social and emotional support measure and the single parent household measure were calculated by the National Center for Health Statistics using data obtained from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) from surveys done between 2005 and 2009.

Adults and children in single-parent households are both at risk for adverse health outcomes such as mental health problems (including substance abuse, depression, and suicide) and unhealthy behaviors such as smoking and excessive alcohol use.

- 17% of Lincoln County residents report no social or emotional support.
- 35% of Lincoln County children live in a home with a single-parent. Only 3 counties in Oregon have more single-parent homes (Tillamook and Lake County at 39% and Clatsop at 38%).

Community Safety and Violent Crime

Violent crime is represented as an annual rate per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault. High levels of violent crime compromise physical safety and psychological well-being. Crime rates can also deter residents from pursuing healthy behaviors such as exercising out-of-doors. Additionally, some evidence indicates that increased stress levels may contribute to obesity prevalence, even after controlling for diet and physical activity levels.

The County Health Rankings measures violent crime rates per 100,000 residents taken from the FBI's Uniform Crime Reports data from 2005-07. This tool gathers information on four offenses: murder and non-negligent manslaughter, forcible rape, robbery and aggravated assault.

- There were 319 reports of violent crime from the FUCR for Lincoln County during the time period considered for the County Health Ranking project. This translates to a rate of 304/100,000 population. This rate of crime puts Lincoln County at 5th highest in Oregon; the state's rate is 275/100,000.

Environmental Factors

Lincoln County Ranking: 27th of 33 Counties

Air Quality

The County Health Ranking project defines air pollution as a measure that represents the annual number of days that air quality was unhealthy for sensitive populations due to fine particulate matter (FPM, < 2.5 µm in diameter). This data was obtained from the Public Health Air Surveillance Evaluation (PHASE) project during 2006. The relationship between elevated air pollution—particularly fine particulate matter and ozone—and compromised health has been well documented. The negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects.

- Lincoln County had 11 days recorded where air pollution-particulate matter was a concern for our local population.
- Lincoln County had 0 air pollution/ozone days.

Access to Healthy Foods

Access to healthy foods is measured as the percent of zip codes in a county with a healthy food outlet, defined as a grocery store or produce stand/farmers' market. In 2011, the measure was based on the percent of residential Zip codes in a county with a healthy food outlet, defined as grocery stores or produce stands/farmers' markets. Studies have linked the food environment to consumption of healthy food and overall health outcomes.

- Only 47% of our county residents live in locations that have a healthy food outlet. This compares to 62% the rest of Oregon residents.

Access to Recreational Facilities

The availability of recreational facilities can influence individuals' and communities' choices to engage in physical activity. Proximity to places with recreational opportunities is associated with higher physical activity levels, which in turn is associated with lower rates of adverse health outcomes associated with poor diet, lack of physical activity, and obesity.

- The Lincoln County recreational facilities access rate is 7/100,00 population, with only 3 identified recreational facilities identified in the county. Only 2 counties in Oregon have a lower rate of access to recreational facilities for their residents (Tillamook and Malheur counties).
- The coastal climate issues experienced by Lincoln County residents elevates the need for both adults and children to have access to recreational facilities at an affordable/free cost which are protected from the elements. Exercise is directly linked to many of the adverse physical and mental health data measures contained in the County Health Ranking report.
- Opportunities may exist within community efforts of the Childhood Obesity Workgroup to identify other facilities for recreational use (i.e. school properties) and/or work with private recreational facilities for subsidized admission prices supported by fund raising or grant efforts.

C. INVENTORY OF COMMUNITY PLANNING PROCESSES

Since 2002, multiple community planning processes have helped to define Public Health issues and needs. These processes are detailed as follows:

Community Health Improvement Partnership (CHIP)	Began October 2002 (Continuing process)
Healthy Active Oregon Institute	June 2004
Federally Qualified Health Center	Established July 2006 (Continuing process)
Public Health Assessment	December 2004
Maternal Child Health Assessment	December 2004
League of Women Voters Child Health Study	July 2005
Managing Chronic Care Through Collaboration Conference	October 2005
Chronic Care Committee	October 2005 (Continuing process)
Community Workshop Local School District Wellness Policy	January 2006
Lincoln Commission on Children and Families Strategic Planning	January 2007 (Continuing process)
Teen Reproductive Health	2007 (Continuing process)
Teen Survey	
Lincoln County School District	Contract amendment process (finalized December 2008)
CHANGE (Community Health Assessment and Change Evaluation)	December 2010-Current

D. PROVISION OF FIVE BASIC SERVICES – (ORS 431.416)

431.416 Local public health authority or health district; duties. The local public health authority or health district shall:

(1) Administer and enforce the rules of the local public health authority or the health district and public health laws and rules of the Oregon Health Authority.

(2) Assure activities necessary for the preservation of health or prevention of disease in the area under its jurisdiction as provided in the annual plan of the authority or district are performed. These activities shall include but not be limited to:

- (a) Epidemiology and control of preventable diseases and disorders;
- (b) Parent and child health services, including family planning clinics as described in ORS 435.205;
- (c) Collection and reporting of health statistics;
- (d) Health information and referral services; and
- (e) Environmental health services. [1961 c.610 §8; 1973 c.829 §23; 1977 c.582 §28; 1983 c.398 §4; 2001 c.900 §150; 2009 c.595 §563]

In addition to ORS 431.416, Lincoln County Health and Human Services provides the following services:

- Primary care provided through Lincoln Community Health Center (our Federally Qualified Health Center) at locations in Newport and Lincoln City.
- Primary care provided through School Based Health Centers at 4 sites in Toledo, Newport, South County, and Lincoln City.
- Public Health Emergency Preparedness and Response
- Tobacco Control and Prevention
- Coordination of “Living Well with Chronic Disease” for county residents (an evidence based intervention from Stanford University)

In direct reference to ORS 431.416 (cited above) the following quote is provided from the Lincoln County Triennial Review completed in February and March 2011:

“The Oregon Health Authority, Public Health Division evaluated county public health programs for compliance with state and federal public health laws and compliance with the Financial Assistance Agreements. The review included appraisal of 1,408 separate items in 17 program areas. While there were some areas that need attention, keep in mind that the vast majority of the findings were positive. Overall, agency reviewers believe the Lincoln County Public Health Division staff is composed of a committed team of professionals who deliver quality public health services to the community.”

Additional reference to data examined during the triennial review process and improvement plans will be cited in later program sections of this annual report.



LINCOLN COUNTY

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III. ACTION PLAN

A. EPIDEMIOLOGY AND CONTROL OF PREVENTABLE DISEASES AND DISORDERS

Program Update:

All cases of reportable communicable disease are investigated according to Oregon Health Authority Public Health Division current Investigative Guidelines with efforts reported on a “real time” basis into the ORPHEUS secure system. The time of data entry into ORPHEUS (as well as telephone/e-mail/fax contact with state PH staff) constitutes the calculation of timeliness of data entry as well as the completeness and completion of investigation; these items constitute the standard for judgment for local PH Performance.

During FY 2009-10, Lincoln County PH Division made the transition from a single Communicable Disease Program Manager and a single Environmental Health Program Manager being responsible for call on a 24/7 basis and investigation and reporting of all communicable diseases to a model that includes 24/7 call being shared between a team of 6 staff; all staff have had Epi 101, 202 and 303 training. The team is a combination of staff and management with representation from both RNs and Environmental Health Specialists. The 24/7 teams works on a coordinated basis and all CD reports are de-briefed as a group during our bi-weekly CD Meeting with our County Health Officer. In cases of outbreaks or a larger investigation, the 24/7 team does a daily “stand up” meeting to assure that all members have all the details and agency efforts are coordinated. Any release of public information related to investigations is coordinated through the our county public information officer, with details being provided by the team and the PH Division Director.

Surveillance:

An Active Surveillance Plan for Public Health is in place within Lincoln County Health and Human Services to gather data about the numbers of people injured or ill following a large-scale outbreak or disaster. During the recent H1N1 event local PH staff worked closely with Lincoln County School District and our Regional Hospital Preparedness staff to develop and implement surveillance tools to monitor illness. In addition, we expanded the capacity to obtain “live” inventory counts from every county pharmacy of anti-viral doses as an additional method of monitoring community illness patterns. Daily food-borne related illness complaints are logged and investigated by PH staff in both the communicable disease and environmental health programs. Additional surveillance tools have been developed specifically for surveillance of radiological and chemical events. Monthly statistics are reported from DHS to LCHHS on county disease incidence and reporting compliance.

Immunizations and Flu:

Lincoln County is somewhat unusual in terms of local public health agencies in continuing to provide all immunizations available for children and adults at LCHHS (e.g., required and recommended childhood immunizations, children and adults at risk for Hepatitis A/B, HPV). In addition, influenza vaccinations are offered by PH in a number of off-site clinics as well as via walk-in clinics at the PH offices during the flu season. During the 2010-11 flu season PH ordered 4,000 doses of private supply flu vaccine. Management of influenza vaccination continues (post H1N1) to be a challenging event for local PH; shipment dates of vaccine are difficult to predict, ancillary private providers and pharmacies who choose to administer flu vaccine affect demand by the public for vaccination at local PH clinics and office, and public “uptake” is highly variable depending on the perceived availability and perceived severity of the circulating virus. Rabies vaccine is available through DHS. Treatment can be given locally. The shingles vaccine (Zostavax) continues to be available for those 60 years of age and above. This vaccine represents a cost burden for local public health to maintain in inventory, as well as for residents to pay “out of pocket” to receive. We keep

limited doses on hand and forecast the need for additional vaccine as appointments are scheduled in the future so that we can do “just in time” ordering to meet local needs and avoid excessive carrying costs of inventory.

Education:

Educational materials are routinely obtained through DHS and the CDC to help provide information and guidance to clients, local health care providers and the media. Blast fax and e-mail are used to disseminate information in a timely manner. These resources provide templates for letters to be used in the case of an outbreak.

Health Alert Network (HAN):

The Health Alert Network is used to communicate emergency information to public health, hospital, tribal, law enforcement, fire and other first responders. This system, formally known as “Alert” has been revamped and has become a much more effective communication and notification tool. Our county PIO (Casey White) serves as the local HAN administrator.

Tuberculosis Case Management Update

No local cases of TB were identified in 2010. In the Triennial Review, Office of Disease Prevention and Epidemiology reports that “*LPHA is in compliance with all program requirements.*”

Tobacco Prevention, Education and Control Update

Lincoln County PH Division is in a grantee relationship with the OR State PH Division to do Tobacco Prevention, Education and Control. As a grantee, we are required to submit an extensive RFA for funding; that RFA was submitted in April 2010 for FY 2011-12 funding. Based on a review of the locally submitted RFA and a negotiation with state staff, a local work plan is approved. The work plan for FY 2011-12 is available for any interested party by request.

Our local tobacco program had a history of using our Public Health Advisory Committee to meet the requirements of the state to have a coalition related to tobacco prevention. During the fall of 2009 (with encouragement from OR State Health Division staff) Lincoln County PH Division began recruiting community members for the development of a local coalition specific to Tobacco Prevention efforts. That coalition had 2 meetings in 2010 and has met approximately every 6 weeks in 2011 to date; they have developed a mission statement and their meeting agendas are full of information and action step discussions. All meetings are documented via minutes, which are available to the public. The coalition represents membership participation from the business sector, school sector, health sector, our local Commission on Children and Families, as well as invested members from other prevention partners in the community. The Lincoln County Tobacco Advisory Coalition is very concerned about the local rate of tobacco use, particularly as it was highlighted in the County Health Rankings report. They are prioritizing efforts at this time to increase the number of Lincoln County residents who use Quit Line services.

In addition to the efforts of our Tobacco Advisory Coalition, our local PH Advisory Committee has requested and received literature reviews regarding effective “best practice” approaches to decrease community tobacco use. An update about Tobacco Prevention, Education and Control efforts is a standing agenda item on the monthly meeting agenda of the Lincoln County PH Advisory Committee.

In the Triennial Review, Office of Disease Prevention and Epidemiology Tobacco Prevention and Education Program and Healthy Communities program staff report that “*LPHA is in compliance with all program requirements.*”

No Action Plan is being submitted for this section; work plans required by the PH Tobacco Prevention, Education and Control program are on file with our Regional Liaison from OR State PH Division.

Communicable Disease Program Update

Total cases of reportable diseases, Lincoln County, OR

Communicable Disease	2007	2008	2009	2010
Persons living with HIV/AIDS				36
Campylobacteriosis	2	1	6	7
Chlamydiosis	102	104	88	75
Cryptosporidiosis				3
E.Coli 0157	1	5	2	0
Giardia	7	3	7	7
Hepatitis A	4	1	0	0
Hepatitis B	6	5	9	0
Hepatitis C (Acute)	0	1	1	0
Hepatitis C (Chronic)	121	224	152	6
Meningococcal	1	6	0	0
Pertussis	8	0	3	7
Salmonellosis	6	4	0	2
TB	2	0	1	0
Gonorrhea	12	0	12	12
Syphilis	0	0	0	0

Review of Timeliness of Attention to Communicable Diseases

Timeliness of First Report from LHD to State (Report to State Date-LHD Report Date)

Timeliness of Interview of Cases

1/1/2008-12/31/2009 (from 2011 Triennial Review Data)

Lincoln County HD: 228 total cases
 100% reported within 1 day
 100% interviewed within 1 day

This data shows improvement from earlier years; In 2007, Lincoln County had 145 total cases, with 116 or 80% reported within 1 day and 29 of 20% reported in 2-5 days.

Timeliness of Completion of Investigation (Completion Date-LHD Report Date)

1/1/2008-12/31/2009 (from 2011 Triennial Review Data)

*Completion of investigation = closed

Lincoln County HD: 228 total cases
61% closed within 10 days
2.2% closed within 11-14 days
36.8% closed after 14 days

228 total cases
74% of interviewed cases closed within 10 days
4% of interviewed cases closed within 11-14 days
22% of interviewed cases closed after 14 days

Completeness (ie Thoroughness) of Case Investigation

1/1/2008-12/31/2009 (from 2011 Triennial Review Data)

Lincoln County HD: A sample of 19 cases were reviewed for case completeness (excluding Hep C, Giardia, Campy, and Crypto and STDs)
100% interviewed
94.7% had identified race information
94.7% had ethnicity information
100% had address information
26.3% had occupation information
89.5% had appropriate risks identified based on Inv. Guidelines
100% had hospitalization status documented
100% had outcome information

Timeliness of Interview (Case Interview Date-LHD Report Date)

1/1/2008-12/31/2009 (from 2011 Triennial Review Data)

Lincoln County HD: 228 total cases
50 interviews completed
48% of interviews completed within 1 day
4% of interviews completed within 2-5 days
20% of interviews completed within 6-10 days
26% of interviews completed after 10 days

Outbreak Investigations

1/1/2008-12/31/2009 (from 2011 Triennial Review Data)

Lincoln County HD: 9 outbreaks occurred in Lincoln County during this time
4 of these outbreaks occurred in long term care facilities
87.5% of all outbreaks were investigated
100% of outbreaks were reported to state staff < 1 working day
In 62.5% of outbreaks, adequate specimens were obtained
In 100% of outbreaks there was adequate case finding for a common cause.
50% of staff in facilities where an outbreak occurred had required food handler identification.

Communicable Disease Improvement Plan

It should be noted that during the Triennial Review, staff representing the Office of Disease Prevention and Epidemiology Acute and Communicable Disease Program reported that *“The LPHA is in compliance with all program requirements”*.

Nonetheless, from an agency perspective, Lincoln County PH Division takes the statutory obligation of communicable disease investigation and reporting very seriously and desires improvement in performance in those areas where it is possible within resources to do so.

Timeliness of Completion of Investigation:

This data shows a decrease from that of 2007; in that year, 95% of investigations were closed within 10 days. There has been discussion with Oregon Health Authority Public Health Division staff that implementation of the Orpheus system at both the local and state level has resulted in data “glitches” in which local staff felt that cases were closed but the system did not reflect that status when reviewed by the state.

Internally, the HHS Division Director and the CD Program Manager are committed to pulling monthly reports from the ORPHEUS system to identify areas where local performance falls short of complete or timely standards on each reported communicable disease. Using a CQI model (continuous quality improvement) management and staff will work to fully complete and close investigations and assure that ORPHEUS reflects those efforts. If needed, management and staff will work in collaboration with state staff to assure that data discrepancies are corrected.

Timeliness of Interview:

Best practice indicates that the interview process undertaken by an experienced public health professional on a timely basis is a valuable part of communicable disease investigation and yields information that may be critical for larger efforts to control the spread of communicable disease. Lincoln County PH experienced reduced response capacity during 2010 as a new Communicable Disease RN was hired and trained. The department is analyzing how to better conduct thorough and complete investigations and complete all necessary steps to close an investigation in a timely way during times of staff transition and potential resource decreases for staff. These internal efforts are critical, as we now are acting on a resignation notice for this same staff person and there is anticipated transition during the upcoming FY 2011-12 in this key position for our department.

Parent and Child Health Services Program Update

It is a requirement of the Annual Plan process to submit the FY 2011-12 WIC Nutrition Education Plan. This plan is contained below; but readers should be aware that it should be considered a “draft”; it has been submitted via our MCH Program Manager but not yet formally accepted by WIC staff at the state level. Italicized language represents our edits which may be subject to further revision.

FY 2011 - 2012 WIC Nutrition Education Plan Form

County/Agency: Lincoln County Health and Human Services WIC

Person Completing Form: Shelley Paeth RN

Date: 4/22/2011

Phone Number: 541-265-0412

Email Address: spaeth@co.lincoln.or.us

**Goal:
prov**

Return this form electronically (attached to email) to: sara.e.sloan@state.or.us

by May 1, 2011

Sara Sloan, 971-673-0043

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:

All WIC staff will attend the Fall 2011 Group Participant Centered training.

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 Fall 2010 and Spring 2011.

Implementation Plan and Timeline:

1. Staff in-service on PCE skills and strategies to use in group education will take place by Oct 2011.
2. During the staff in-service, a discussion will take place and suggestions made to modify one nutrition education group lesson plan from each category of core classes.
3. Actual modifications will take place by March 30, 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:

1. A Staff in-service on second nutrition education options for clients will take place by March 30, 2012.
2. The staff in-service will review: content and design of second nutrition education options and how to assist participants in selecting the nutrition education experience that best fits their needs.

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:

1. Staff in-service on PCE skills and strategies to use in group education will take place by Oct 2011.
2. During the staff in-service, a discussion will take place and suggestions made to modify at least one prenatal breastfeeding class.
3. Actual modifications will take place by March 30, 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:

1. Breastfeeding Coordinator will provide an in-service to staff on how to incorporate PCE skills to support breastfeeding by Dec 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 least 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:

1. At a staff meeting in July 2011; staff will brainstorm on which community partners serve WIC participants and provide nutrition education and invite them to a regional Group participant education 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:

1. At a staff meeting in July 2011; Staff will brainstorm on which community partners provide breastfeeding education to WIC participants and invite them to Breastfeeding basics- Grow and Glow training; complete the Oregon WIC breastfeeding module or complete the online breastfeeding course when available.
2. By December 2011, invite the community partner to the appropriate breastfeeding education.

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:

1. Provide in-service to WIC staff on Health Outcomes (in-service provided by State WIC) by March 31, 2012

Activity 2: Local agency staff will complete the new online Postpartum Nutrition

Course by March 31, 2012.

Implementation Plan and Timeline:

1. Staff will complete the new online Postpartum course 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):

**Attachment A
FY 2011-2012 WIC Nutrition Education Plan
WIC Staff Training Plan – 7/1/2011 through 6/30/2012**

**Agency: Lincoln County PH Division, Lincoln HHS
Training Supervisor(s) and Credentials: Shelley Paeth, RN, BSN, MCH Program Manager**

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	July 2011	Staff in-service on how to incorporate PCE skills to support breastfeeding.	1. Discuss with staff which PCE skills are appropriate to use with supporting breastfeeding. 2. Discuss Staffs personal history with breastfeeding and how it affects there use of PCE skills in supporting breastfeeding.
2	October 2011	Attend State sponsored Group participant centered training.	1. To continue to develop staffs knowledge, skills and abilities for providing quality participant centered services.
3	February 2012	Staff in-service on: 1. Second nutrition education options for clients. 2. A review of content and design of these second nutrition education options. 3. How to assist participants in selecting the nutrition education experience that best first their needs.	To continue to develop WIC staff knowledge, skills and abilities for providing quality participant centered services.
4	May 2012	Staff in-service to WIC staff on factors influencing Health outcomes.	To increase WIC staff understanding of the factors influencing health outcomes in order to provide quality nutrition education.

MCH Action Plan for EMR for MCH Documentation **Time Period: May 2011**
GOAL: To use EMR in MCH RN home visiting programs.

Objectives	Plan for Methods/Activities/Practice	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
Staff proficiency in electronic charting (Champs EMR software) by 3/2011.	Provide training on use of Champs software.	Did all RN staff attend EMR training?	All MCH RN staff are trained on CHAMPS EMR software for documentation of HV services.	<i>Training is still in progress; all staff have completed 4 of 6 required homework sessions and joint trainings. Trainings are occurring on alternate Wednesdays from 6-8 AM</i>
Begin using EMR by 3/2011.	Have meetings to plan for transition from paper to EMR.	Did all RN staff attend transition meetings?	All MCH RN staff are utilizing CHAMPS EMR software for documentation of HV services	<i>EMR implementation is scheduled for July 1st, 2011. This delay of our original goal is to allow all training to be completed and for changes in our training data base to be completed before implementation.</i>

MCH Action Plan for OMAHA for MCH Documentation **Time Period: May 2011**
GOAL: To use the OMAHA system of documentation in MCH RN home visiting programs

Objectives	Plan for Methods/Activities/Practice	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
To be trained on the OMAHA system of documentation by 3/2011.	Have meetings to plan for transition from SOAP charting to the OMAHA system. Attend training on the OMAHA system of charting.	Did RN staff attend transition meetings? Did RN staff attend Omaha system of documentation training?	MCH RN staff develop and implement a successful plan for supported learning for transition from paper-based SOAP charting to new nursing "language"	<i>All Staff participated in the Omaha Basics Workshop in September, 2010 with national expert Karen Martin. Staff worked with their program manager to complete a series of case studies provided at the training in subsequent months. In December of 2010, all staff traveled to Bremerton, WA to participate in a peer learning exercise with PH RNs in the Bremerton-Kitsap County Health Department. This Health Department has been using the same system as we have purchased for a number of years. Staff were able to observe HV and then observe documentation in the EMR using Omaha language. These training efforts have prepared staff well for our local training and implementation.</i>

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IV. ADDITIONAL REQUIREMENTS

SB 555

Effective July 1, 2007, the Lincoln County Commission on Children and Families (LCCF) moved from Lincoln County Health and Human Services to become a separate county department. Coordination for the children 0-18 comprehensive plan occurs on many levels with public health. The Director of LCCF and the MCH Program Manager both sit on the local Early Childhood Coordination Council, which is Advisory to the Commission on Children 0-8 with the primary focus on 0-5. The LCCF Director attends and has applied for membership on the Public Health Advisory Committee. Two managers for Human Services have been recommended for LCCF membership when they add new members, the School Based Health Center Program Manager as well as the Maternal Child Health Program Manager.

Organizational Chart

Following is the local Public Health Organizational Chart.

Board of Health

The Lincoln County Board of Commissioners serve as the Board of Health for Lincoln County. The County Commissioners designate one member who serves in an official liaison capacity with Lincoln County Health and Human Services. The HHS Director (representing PH as well as other areas) meets and confers regularly with the BOCC liaison. PH presents regularly to the BOCC/Board of Health on topics as needed and/or requested. Annually in conjunction with the BOCC/Board of Health approval of the PH Annual Plan, public health program staff highlight their programmatic achievements in a public meeting. Other occasions in the past year where presentations have occurred have related to H1N1, the County Ranking Project, Health Care Reform, and new programs started with grant awards.

Public Health Advisory Body

Lincoln County Public Health is fortunate to have a dedicated body to advise, review, and guide our public health practice. The Lincoln County PH Advisory Council meets monthly and has been responsible for leading major initiatives related to county health efforts (minutes and member roster available upon request). Members of this group are appointed by County Commissioners after recommendation by the body. The Public Health Advisory Council regularly reviews agency performance data, as well as formally reviews and votes to accept the Annual PH Plan before it goes to the BOCC/Board of Health for final approval and signature.

**Lincoln County Health and Human Services
Public Health Division
Organizational Chart**

Updated May 2011

Department Organizational Chart



LINCOLN COUNTY

PUBLIC HEALTH

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V. UNMET NEEDS

Comprehensive Plan Unmet Needs 2008 - 2011

- Adequate funding for both local and state Public Health System.
- Nutrition education for all WIC clients.
- Extensive health promotion and prevention.
- Mental Health services during all home visits.
- Information and referral (food, clothing, heat) when financial needs change.
- Community wide approach to reduce obesity and promote healthy nutrition and exercise.
- Additional staffing for grant writing, health promotion and prevention, and Epidemiology.
- Reporting of Public Health statistics, data and trends to the public.
- Physician contact and information regarding public health data analysis and community planning.
- Public Agencies do not always have up-to-date information about PH Programs and services.
- Preventative dental care for children and adults.
- Increase services for seniors for dental care, disease education, prevention and disease management.
- Nutrition education beyond WIC and Diabetes programs.
- More bilingual staff.
- Ongoing support for My Future My Choice (previously STARS)
- Maternity Case Management visits for nurse assessed risk beyond OHP determined number of visits.
- Ongoing parenting classes for ages 0-3 years.
- Increased BH services including A & D, as well as comprehensive tobacco cessation services to improve individual and community wellness.



LINCOLN COUNTY

PUBLIC HEALTH

ANNUAL PLAN

2011

May 2011

VI. BUDGET

Contact Information for
Lincoln County Health and Human Services Department Budget

Lincoln County Health & Human
Services

Attention: Kari Hall

36 SW Nye Street

Newport, OR 97365

541-265-6611 x2332

khall@co.lincoln.or.us



LINCOLN COUNTY

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VII. MINIMUM STANDARDS

VII. Minimum Standards

Required

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

I. Organization

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

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

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

Control of Communicable Diseases

37. Yes ___ No ___ There is a mechanism for reporting communicable disease cases to the health department.
38. Yes ___ No ___ Investigations of reportable conditions and communicable disease cases are conducted, control measures are carried out, investigation report forms are completed and submitted in the manner and time frame specified for the particular disease in the Oregon Communicable Disease Guidelines.
39. Yes ___ No ___ Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or communicable disease case received.

40. Yes ___ No ___ Access to prevention, diagnosis, and treatment services for reportable communicable diseases is assured when relevant to protecting the health of the public.
41. Yes ___ No ___ There is an ongoing/demonstrated effort by the local health department to maintain and/or increase timely reporting of reportable communicable diseases and conditions.
42. Yes ___ No ___ There is a mechanism for reporting and following up on zoonotic diseases to the local health department.
43. Yes ___ No ___ A system exists for the surveillance and analysis of the incidence and prevalence of communicable diseases.
44. Yes ___ No ___ Annual reviews and analysis are conducted of five year averages of incidence rates reported in the Communicable Disease Statistical Summary, and evaluation of data are used for future program planning.
45. Yes ___ No ___ Immunizations for human target populations are available within the local health department jurisdiction.
46. Yes ___ No ___ Rabies immunizations for animal target populations are available within the local health department jurisdiction.

Environmental Health

47. Yes ___ No ___ Food service facilities are licensed and inspected as required by Chapter 333 Division 12.
48. Yes ___ No ___ Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.
49. Yes ___ No ___ Training in first aid for choking is available for food service workers.
50. Yes ___ No ___ Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided.
51. Yes ___ No ___ Each drinking water system conducts water quality monitoring and maintains testing frequencies based on the size and classification of system.
52. Yes ___ No ___ Each drinking water system is monitored for compliance with applicable standards based on system size, type, and epidemiological risk.

53. Yes ___ No ___ Compliance assistance is provided to public water systems that violate requirements.
54. Yes ___ No ___ All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken.
55. Yes ___ No ___ A written plan exists for responding to emergencies involving public water systems.
56. Yes ___ No ___ Information for developing a safe water supply is available to people using on-site individual wells and springs.
57. Yes ___ No ___ A program exists to monitor, issue permits, and inspect on-site sewage disposal systems.
58. Yes ___ No ___ Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.
59. Yes ___ No ___ School and public facilities food service operations are inspected for health and safety risks.
60. Yes ___ No ___ Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12.
61. Yes ___ No ___ A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste.
62. Yes ___ No ___ Indoor clean air complaints in licensed facilities are investigated.
63. Yes ___ No ___ Environmental contamination potentially impacting public health or the environment is investigated.
64. Yes ___ No ___ The health and safety of the public is being protected through hazardous incidence investigation and response.
65. Yes ___ No ___ Emergency environmental health and sanitation are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control.
66. Yes ___ No ___ All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448.

Health Education and Health Promotion

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

Nutrition

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

Older Adult Health

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

Parent and Child Health

82. Yes ___ No ___ Perinatal care is provided directly or by referral.
83. Yes ___ No ___ Immunizations are provided for infants, children, adolescents and adults either directly or by referral.
84. Yes ___ No ___ Comprehensive family planning services are provided directly or by referral.
85. Yes ___ No ___ Services for the early detection and follow up of abnormal growth, development and other health problems of infants and children are provided directly or by referral.
86. Yes ___ No ___ Child abuse prevention and treatment services are provided directly or by referral.
87. Yes ___ No ___ There is a system or mechanism in place to assure participation in multi-disciplinary teams addressing abuse and domestic violence.
88. Yes ___ No ___ There is a system in place for identifying and following up on high risk infants.
89. Yes ___ No ___ There is a system in place to follow up on all reported SIDS deaths.

90. Yes ___ No ___ Preventive oral health services are provided directly or by referral.
91. Yes ___ No ___ Use of fluoride is promoted, either through water fluoridation or use of fluoride mouth rinse or tablets.
92. Yes ___ No ___ Injury prevention services are provided within the community.

Primary Health Care

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

Cultural Competency

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

II. Health Department Personnel Qualifications

Required

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: _____

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

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

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

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

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

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

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

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

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

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

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

AND

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

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

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

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

OR

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

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

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

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

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

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.

Local Public Health Authority

County

Date