

**Union County, Oregon
Local Public Health Authority Annual Plan
2011-2012**

**Center for Human Development, Inc.
2301 Cove Avenue
La Grande, OR 97850**

I. Executive Summary

Center for Human Development, Inc. (CHD) is a nonprofit organization responsible for providing public health services in Union County, Oregon. CHD is successful in assuring that local public health services are adequate for meeting, and in some cases exceeding, minimum requirements. Although there are still serious health concerns and economic challenges in our community, we are proud that CHD is able to assure that statutorily mandated public health services are provided to Union County residents. In the past year we have continued to increase service and quality levels in all five basic services contained in statute (ORS 431.416) and rule while continuing to identify and address other needs that are unique to Union County.

CHD's priority public health goals in the next year are to continue increasing the number and scope of services we provide to Union County residents. We will also focus on increasing quality improvement and assurance activities as we work toward becoming an accredited local public health department. This will include more comprehensive community assessment activities and greater engagement with community partners.

The biggest resource available to us continues to be our highly trained and motivated staff, and our strong and active community partnerships. Our staff is extremely committed to attaining our mission of "Working for Healthy Communities" and because our resources are extremely limited they often go above and beyond to help meet the needs of those we serve. Another asset is CHD's nonprofit status, which allows us to seek grants that support work beyond our state and county supported public health programs. We have had success in securing grants, but these programs are often time limited. While grantseeking is always limited by the small amount of time our staff has to devote to this work, we will continue our efforts to raise funds in the future to augment our ability to engage in prevention and population-based work.

Our biggest challenge continues to be increasing and unmet community need, primarily due to our rural location, tenuous economic status, and lack of resources to meet significant needs. We continue to wrestle with long term solutions to meet the resource needs for public health infrastructure in our county by seeking outside or non-traditional funding and partnerships wherever we can.

In fiscal year 2013 there are likely to be significant changes in Oregon related to the delivery of health care, public health, mental health, and education services. Health care transformation and educational reform are likely to change the way public health services are provided in Union County, yet at this point exactly how is unknown. CHD is working to be proactive in responding to this new environment. Because CHD has a unique structure where Union County's local public health authority and county mental health program are housed in one organization, there is already some collaboration between physical and behavioral health services, and we are now exploring approaches to enhance this integration. CHD is also working with the local hospital and organizations that are preparing to become Coordinated Care Organizations to develop early partnerships and help prepare our county for upcoming changes. CHD has also been keeping on top of changes that are being proposed for Oregon's early learning system and thinking of ways public health can support these efforts as they move forward.

II. Assessment

Demographics and Public Health Indicators

Union County, Oregon is a rural area with a population of 25,748 people. Over half (13,082) of the County's residents live in the largest town, La Grande. As a result, a majority of health care and social services are based in this community. The county's remaining residents primarily live in five smaller communities: Elgin (1,711), Imbler (306), Cove (552), Union (2,121), and North Powder (439). (Source: 2010 Census, Portland State Population Research Center)

Unemployment continues to be an issue in Union County, although current numbers are similar to the state. According to the Oregon Employment Department, in November 2011 Union County had a seasonally adjusted unemployment rate of 9.6%, compared to 9.1% in Oregon. This number is an improvement over Union County's rate of 10.4% in November 2010.

Limited financial resources are a problem for Union County residents. According to the Oregon Housing and Community Services 2010 Report on Poverty, the rate of poverty in Union County was 15% for 2005-2009. This is one percent higher than Oregon's rate of 14%. The bulk of persons living in poverty in Union County's total population were children younger than 18 (21%) and the majority of families living in poverty were single women with children under 18 (48%). In 2009 48% of Union County students were eligible free/reduced lunch. Union County's median household income of \$40,542 in 2009 was also lower than Oregon (\$49,033) and the United States (\$51,425).

According to Children First for Oregon's Status of Oregon's Children 2010, the number of children living in poverty in Union County was 21.5%, which is 9% worse than the previous year. This report also shows that the number of students eligible for free and reduced lunch is high: the percentage of students eligible in Union County schools for 2008-2009 ranged from a low of 26% in Cove School District, to a high of 56.7% in Elgin School District.

Union County residents are uninsured at high rates—in 2005 18% were uninsured. This figure is close to that of Oregon with 19% of residents uninsured. Our total county Oregon Health Plan (OHP) eligible are about 12%, indicating that young families are hit hard by socioeconomic factors. For 2007, 47% of the births in Union County were either Medicaid/OHP (44%) or self pay/no insurance (3%). We know that underinsurance rates are a growing problem as many companies have to raise deductibles and co-pays while reducing benefits in order to continue to offer health insurance to their employees.

In addition to these socioeconomic factors, there are a number of specific public health indicators that demonstrate the issues and areas of need experienced by residents of Union County. Key health indicators are as follows.

Teen Pregnancy: Teen pregnancy is an important indicator of public health in our community, yet lack of data creates challenges in understanding the scope of this issue. The most recent final data available from the state is from 2009, when there were 37 births to Union County women ages 15-19. This number represents 11.78% of Union County's total births, which is higher than the 8.63% of Oregon's total births that occurred in this age category. In 2009 the pregnancy rate

among Union County 10-17 year olds was 7.0 compared to Oregon's rate of 8.9, and among ages 15-17 the rate was 16.4 compared to Oregon's rate of 22.5. These rates represent a slight decrease from the previous rate of 9.0 among 10-17 year olds in 2007. Sources: Oregon Health Authority Teen Pregnancy Data, Oregon Vital Statistics County Data 2009

Women In Need of Family Planning: After a drastic increase in 2010 to 2,648, the number of "women in need" of family planning services (women between 13 and 44 years of age, fertile, sexually active, neither intentionally pregnant or not trying to become pregnant and at an income less than 250% of federal poverty level) in Union County decreased in 2011 to 1,820. This is more aligned with fiscal year 2009 (1,867). The number of Union County women in need served in 2011 was 771, an increase from the previous three years: 2010 (748), fiscal year 2009 (768), and fiscal year 2008 (717). The estimated percentage of "women in need" served increased in 2011 to 42.4%, up from 28% in 2010, and was more aligned with previous years (40.2% in fiscal year 2009 and 44.3% in fiscal year 2008). Source: Oregon Health Authority Family Planning Facts

Low Birthweight: The rate of all low birthweight infants in Union County for 2009 was 95.5 compared to 63.0 for Oregon. The low birthweight rate for 1,500-2,499 was significantly different from the state rate at 86.0 compared to 52.6. The 2009 rate reflects an upward trend and a significant increase over previous year's rates of 69.7 in 2008, 54.4 in 2007, 68.5 in 2006, and 55.0 in 2005. Source: Oregon Health Authority Birth Data.

Chronic Diseases: An examination of the age-adjusted prevalence of chronic conditions among adults in Union County compared with Oregon as a whole shows that our county fairs better and worse in some areas. Information on specific diseases is below.

Arthritis: The age-adjusted prevalence of arthritis among adults in Union County for 2006-2009 was 31.0%, higher than Oregon's prevalence of 25.8%. Source: Oregon's Arthritis Report 2011

Asthma: The age-adjusted prevalence of asthma among adults in Union County for 2004-2007 was 10.9%, compared to 9.9% in Oregon. The percentage of eighth graders with current asthma in 2007-2008 was 11.1, the same as Oregon. The percentage of eleventh graders with current asthma during the same period was higher than Oregon at 8.9 versus 11.2. According to the Oregon Asthma Program, data from 2004-2005 shows Union County had one of the highest overall asthma control scores (indicating poor asthma control) among children ages 0-17 years on Medicaid: the average annual score for children in Union County was 2.8, the third lowest behind Clatsop and Coos counties (4.4 and 3.7 respectively). Union County had the highest asthma emergency department visits for Oregon children with asthma on Medicaid at 26.0 visits per 100 children with asthma per year. Union County was second among counties with the highest rates of children with low medication ratios, which indicates they have too few controller medication dispensings, too many rescue medication dispensings, or both. Among Oregon children with persistent asthma on Medicaid, 68.0 per 100 Union County children with persistent had low medication ratios. Sources: The Burden of Asthma in Oregon:

2010; Geographic Disparities in Pediatric Asthma Control among Oregon Children on Medicaid, January 2008.

Cancer: Cancer incidence and mortality is generally lower in Union County than Oregon, with a few negative variations that set it apart from the state. From 1997-2006 Union County's all cancer incidence rate of 466 was lower than Oregon's rate of 482 and Union County's all cancer mortality rate of 192 was lower than Oregon's rate of 196. During the same 1997-2006 period in Union County, compared to Oregon as a whole, colorectal cancer mortality was significantly higher (24 versus 18), prostate cancer incidence was significantly higher Oregon (197 versus 158), and stomach cancer mortality was significantly higher (6 versus 3). Source: Cancer in Oregon, 2006

Chronic Lower Respiratory Disease: The age-adjusted prevalence of Chronic Lower Respiratory Disease was 49.1 per 100,000 for Oregon versus 52.4 per 100,000 in Union County in 2000-2004. Source: Keeping Oregonians Healthy

Coronary Heart Disease: The age-adjusted prevalence of coronary heart disease among adults in Union County for 2006-2009 was 4.0%, compared to 2.7% in Oregon. Source: Oregon BRFSS County Combined Dataset 2006-2009

Diabetes: While the general trend in Oregon is for rural counties to have a higher prevalence of diabetes, Union County's age-adjusted prevalence rate of 6.5% is low when compared to other counties in the State and lower than the State rate of 6.8%. Source: Oregon BRFSS County Combined Dataset 2006-2009

Heart Disease and Stroke: Data shows that Eastern Oregon counties have the highest heart failure death rates, the lowest percentage of people who had cholesterol screening within the past 5 years, and high blood cholesterol prevalence. All of these factors play a role in heart disease and stroke risk. The age-adjusted prevalence of stroke among adults in Union County for 2006-2009 was 3.9%, compared to 2.3% in Oregon. Source: The Burden of Heart Disease and Stroke in Oregon, December 2007, Oregon BRFSS County Combined Dataset 2006-2009

Overweight/Obesity: According to data from 2006-2009, the age-adjusted percentage of Union County adults classified as overweight was 42.8% compared to 36.1% in Oregon. 23.5% of Union County residents were classified as obese compared to 24.5% in Oregon. Among 8th and 11th graders in the Eastern/Central Oregon region obesity and overweight percentages are above that of the State by 1-2%. In 2004-2007 the percentage of Union County adults who consumed at least 5 serving of fruits and vegetables per day was 24.8% compared to 26.6% in Oregon. Among 11th graders the percent at risk of overweight was 16% for Union County compared to 13% for Oregon. Drinking soda is a notable risk factor, with the percentage 11th graders that drank at least 7 sodas per week at 33% in Union County versus 27% in Oregon and the percentage who bought soda at school at least 1 day per week at 39% in Union County versus 32% in Oregon. The percentage who participated in physical education daily was also lower at 17% in Union County compared to 19% in Oregon. The percent of eighth graders at risk for overweight is 18% in Union County versus 15% in Oregon, 19% of Union County eight graders

consumed at least 5 servings of fruits and vegetables per day compared to 24% in Oregon, and the percentage who bought soda at school at least 1 day per week was 24% in Union County compared to 17% in Oregon. Source: Keeping Oregonians Healthy; Oregon Overweight, Obesity, Physical Activity, and Nutrition Facts, January 2007; Oregon BRFSS 2006-2009.

Tobacco: According to the Union County Tobacco Fact Sheet for 2011, cigarette smoking among adults in Union County is lower than Oregon (14% vs. 17%) and represents a decrease from 16% as reported on the 2009 Tobacco Fact Sheet. The Fact Sheet also shows that cigarette smoking among 11th graders decreased in Union County (17% to 15%) and in Oregon (22% to 16%). Cigarette smoking among Union County 8th graders was reported at the same as the state (9%) on the 2011 Fact Sheet, but this is an increase in smoking among eighth graders when compared to 2009 data (5%). The most alarming figure related to tobacco in Union County is the percentage of adult males who use smokeless tobacco: 21% compared to 6% in the state. This number is up from 17% in 2009. The most alarming change is smokeless tobacco use among 11th graders: the 2011 Fact Sheet indicates that 29% use smokeless tobacco. This is compared to the state at 14% and is up from 17% in 2009. Eighth grade smokeless tobacco use is also higher than the state (15% vs. 5%). Tobacco use during pregnancy continues to remain at 18%, higher than 12% in the state. Sources: Union County Tobacco Fact Sheet 2009 and 2011.

Adequacy of Local Public Health Services

Local public health services are adequate for meeting minimum requirements. CHD meets or exceeds all expected standards as evidenced by successful reviews of our programs and services and consistent fulfillment of our organization's contractual obligations. We are proud that CHD is able to assure that statutorily mandated public health services are provided to Union County residents. Given that public health issues in Union County are broad and extend beyond state-mandated programs and services and available funding resources, CHD is constantly striving to identify and creatively respond to issues aimed at achieving CHD's mission of "working for healthy communities."

Extent to Which Local Health Department Assures Five Basic Services

CHD assures the five basic services contained in statute (ORS 431.416) and rule in Union County. CHD employs a full time public health administrator responsible for supporting CHD employees in implementing these services. Epidemiology and control of preventable diseases and disorders are primarily assured by a nurse responsible for communicable disease investigation and control and tuberculosis case management. Our Tobacco Prevention and Education Coordinator also helps assure this basic service by leading tobacco prevention, education, and control efforts. Parent and child health services are assured by a variety of CHD staff. Two nurses coordinate immunization and family planning programs that serve parents and children. Two nurses and three family advocates provide maternal and child health services through public health home visiting for Union County families. A coordinator, certifier, and dietician also assure the delivery of women, infants, and children (WIC) nutrition services. Collection and reporting of health statistics and health information and referral services are assured by all nurses and program staff. A registered environmental health specialist is responsible for all environmental health services. Public health services are also supported by the emergency preparedness coordinator, health officer, and vital records coordinator. A nurse practitioner, nurse, and health assistant help assure many of the basic services are available to

students and other members of the community at two School-Based Health Centers, and a nurse provides school nursing services in three rural school districts. A public health assistant position was recently added to the public health team to support a variety of administrative functions and to enhance health information and referral services.

Adequacy of Other Services of Import to Union County

The number of primary health care providers available in Union County does not meet community needs. Data contained in the 2011 County Health Rankings report shows that the population to primary care physicians ratio in Union County is 809:1, which is lower than Oregon's ratio of 739:1 and the national benchmark: 631:1. This is not extremely high, but there can still be barriers to access. The majority of physicians in Union County are located in La Grande and employed by the local hospital. There is one non-hospital physician practice, also in La Grande. The hospital has brought in a number of new physicians and nurse practitioners serve the community to help increase access. Two communities—Elgin and Union—have health clinics that provide limited health care services and one employs a primary care physician. School-Based Health Centers in two school districts help increase primary care access for students. Most health care and social services require a trip to La Grande, which is anywhere from 15 to 20 miles away from these communities. This might not seem far, but there very limited, if any, public transportation options, and winter driving conditions can be very severe, often causing road closures between La Grande and these communities.

CHD provides dental health services through our WIC and home visiting programs and we are lucky to have an ODS dental hygiene school in our area. While we partner with them extensively to extend dental/oral health resources, the need for accessible, affordable dental health services regularly comes up as an important issue on local needs assessments.

Nutrition services are limited to WIC and home visiting programs, but are vitally needed in all programs and by the community in general. The lack is due both to resource issues and to a shortage of dieticians and nutritionists in the area.

Older adult health services, both preventative and other wise, are almost non-existent in the public health realm, with no other community programs fully closing that gap. Primary health care is very difficult to access for reasons outlined above.

III. Action Plan

A. Epidemiology and Control of Preventable Diseases and Disorders

Current Conditions and Problems:

1. Current Conditions:
 - a. We have several staff in need of CD 303 training.
 - b. Communicable disease reporting is done in a timely manner.
 - c. Active tuberculosis has not been an issue in Union County.
 - d. Cases with Latent Tuberculosis Infections are receiving the recommended treatment.
 - e. Successful tobacco prevention, education, and control efforts have been in place in Union County for four years.

2. Current Problems:
 - a. Training for CD 303 was scheduled in Union County in 2010, but since most staff had not completed the prerequisite CD 101, there was low enrollment and it was cancelled.
 - b. Chlamydia has always been a problem in Union County; in 2008 there were 44 reported cases, in 2010 there were 80 cases, and thru December 27, 2011 there were 98 cases. An examination of the past 5 years shows a continual increase in reported cases.
 - c. There are currently multiple cases of confirmed latent tuberculosis infection in Union County.
 - d. Chronic Hepatitis C cases are steadily increasing in Union County; in 2005 three cases were reported, in 2009 forty cases were reported, in 2011 there were 114 newly confirmed cases reported.
 - e. Investigations for communicable diseases can be hampered by difficulties in getting (timely) information from physicians and individual cases that are reluctant to disclose contact information.
 - f. While we are actively enforcing the Indoor Clean Air Act and *10 ft rule*, we feel that more can be done within Union County to raise awareness of the *10 ft rule*.
 - g. While smoking rates for Union County are the same as or below state rates, smokeless tobacco use by males (8th grade, 11th grade, and adult) far exceeds the state rate. Union County rates are: 15% of 8th graders, 29% of 11th graders and 21% of adult males reporting that they use smokeless tobacco. These rates are similar in other rural Oregon counties.
 - h. Only three of the six Union County School Districts have adopted gold-standard tobacco policy.

Program Goals

1. Employees are up to date on trainings.
2. Lower Chlamydia rates:
 - a. Increase awareness of sexual exposure risk among at risk populations.

- b. Increase condom use.
3. Increase awareness of latent tuberculosis infection risks, prevention, and signs of infection.
4. Increase awareness of Hepatitis C.
5. Promote Hepatitis A and B vaccine for those with chronic Hepatitis C by educating providers and cases.
6. Increase the timeliness of investigation completions.
7. Increase community awareness of the 10 ft. Outdoor Smokefree Zone rule.
8. Increase awareness of the dangers of smokeless tobacco and the high use rates in Union County through a public campaign.
9. Work with three Union County school districts to encourage their adoption of gold standard tobacco policy.

Program Activities

1. Work with state to see how we can obtain CD 303 training in Union County in 2012-2013.
2. Investigate cases of Chlamydia to identify patterns and use those patterns to develop and implement targeted interventions.
3. Supply condoms to Union County bars and nightclubs to increase condom use.
4. Increase condom accessibility throughout the community.
5. Work on improving communication with Union County physicians.
6. Increase number of case interviews across reportable diseases.
7. Implement at least one community education campaign focused on the 10 ft. Outdoor Smokefree Zone rule.
8. Develop a smokeless tobacco tool-kit in conjunction with the TPEP Eastern Oregon Regional Support Network.
9. Participate in the Union County Safe Communities Coalition to increase community awareness of the dangers of smokeless tobacco and use rates in Union County, and over time reduce smokeless tobacco rates in the county.
10. Work with the three Union County school districts to adopt gold-standard tobacco policy.

Program Evaluation

1. All necessary staff receives CD 303 training.
2. Monitor the incidence of STIs, especially Chlamydia and Hepatitis C.
3. Monitor condom distribution to determine if there is an increased availability throughout Union County.
4. Indoor Clean Air Act violations are enforced per state statute.
5. Smokeless tobacco tool-kit is completed and available on-line.
6. Increased community awareness of the dangers of smokeless tobacco and use rates in Union County.
7. Three school districts adopt more stringent gold standard tobacco policies.

B. PARENT AND CHILD HEALTH SERVICES, INCLUDING FAMILY PLANNING CLINICS

Current Conditions and Problems for Home Visiting Programs, School Health and General Parent Child Health

1. Current Conditions

- a.) The Babies First!, Maternity Case Management, and CaCoon programs operated by CHD utilize an innovative approach that pairs nurses and family advocates to provide pregnant/parenting families and their children with services that lead to improved health outcomes in our community.
- b.) Nurses providing other public health services such as immunizations and family planning work closely with home visiting staff to link pregnant/parenting clients with services that support general parent/child health.
- c.) Union County was awarded a Tobacco Prevention and Education Program (TPEP) grant and associated activities have now been in place for four years.
- d.) Oregon Health Sciences University (OHSU) School of Nursing at Eastern Oregon University is in the middle of a community-based participatory research project focusing on childhood obesity called U.C. Fit Kids. CHD staff participates as a member of the coalition.
- e.) The School-Based Health Center at La Grande High School is continuing to provide services to Union County youth. CHD opened a second School-Based Health Center in 2011 at Union School District.
- f.) In 2011 CHD was awarded a \$255,000 federal grant to purchase equipment, including a new Electronic Health Record system, for two School-Based Health Centers.
- g.) CHD provides nursing and behavioral health services in three of Union County's rural school districts.
- h.) CHD was awarded funding to conduct suicide-prevention training and activities in two local schools.
- i.) CHD added a half-time position to its public health team that will spend some time doing outreach and education in areas relevant to general parent child health.

2. Current Problems

- a.) Federal and state efforts to transform health care and early learning are likely to create significant changes for public health home visiting programs including Babies First!, Maternity Case Management, and CaCoon. At this time there is still uncertainty as to what these changes will be and how they will impact the successful service delivery model we are implementing in Union County.
- b.) Increasing number of referrals to the CaCoon program due to feeding problems and associated nutritional issues. Multiple anomalies are also causing an increased number of referrals.
- c.) The rate of low birthweight in Union County was trending up, but 2011 year-to-date data (through September) indicates the number has dropped from a rate of 85.4 to 62.2.

- d.) There is a long term trend of women smoking during pregnancy. Union County rate is consistently higher than Oregon.
- e.) According to the Oregon Smile Survey 2007, school children who live outside of the Portland metropolitan area experience more tooth decay, more untreated decay, and more decay severe enough to require urgent treatment than their urban counterparts. Outside of the metropolitan area, one in 17 students needs urgent care and 70% have already had a cavity.
- f.) Women who are pregnant have an elevated risk of oral disease. According to The Burden of Oral Disease in Oregon report (November 2006), periodontal disease during pregnancy has been associated with low birth weight and pre-term deliveries and poor oral health during pregnancy increases the risk of Early Childhood Caries among offspring. The report states that despite these dangers, less than half of pregnant women in Oregon visit a dentist while pregnant and less than one-third of pregnant women receive information on how to prevent tooth decay in infants.
- a.) In 2007-2008, 16.5% of eighth graders and 17% of 11th graders reported having a physical health need during the last 12 months that was not met.
- b.) In 2005-2006, 34% of eighth graders and 36% of 11th graders reported that a doctor, nurse or other health professional has told them they have one or more chronic health conditions.
- c.) Asthma is a serious issue for Union County youth ages 0-17 years. Union County has one of the highest overall asthma control scores (indicating poor asthma control) among children ages 0-17 years that were on Medicaid and is one of the counties with the highest rates of Emergency Department visits for asthma. In 2007-2008, 18.1% of eighth graders and 20.7% of 11th graders reported that a doctor or nurse had told them they had asthma.
- d.) In 2007-2008, 27.9% of eighth graders were overweight or obese, up from 25.4% in 2005-2006. 27.1% of 11th graders were overweight or obese in 2007-2008, up from 25.9 in 2005-2006.
- e.) In 2007-2008, 11.4% of eighth graders and 14.3% of 11th graders seriously considered suicide.
- f.) While CHD received new funds to support suicide prevention activities in two local high schools through September 2012, soon we will not have funds to address youth suicide utilizing prevention.
- g.) CHD lacks the capacity it needs to conduct outreach, which has a direct correlation to the number of clients learning about and utilizing public health services.

Program Goals

1. Sustain vital public health home visiting services in Union County during a time of uncertainty and transition.
2. Decrease the number of women smoking during pregnancy.
3. Determine relevant factors for low birth weight babies in Union County.
4. Increase the percentage of low birth weight babies that meet developmental milestones.
5. Increase the number of young children who use some dental sealant method.

6. Increase the number of visits for oral health care for pregnant women during pregnancy.
7. Have a health care presence (mental and physical health) in as many schools as possible Union County.
8. Decrease the rate of adolescents who are at risk for being overweight.
9. Decrease percentage of 8th and 11th graders who attempt suicide.

Program Activities

1. Work with state and local partners and internally to plan for and implement any changes related to home visiting programs.
2. Home visiting and WIC certifiers have been trained in and are applying the 5 A's intervention for clients who smoke. As a part of this effort, the TPEP coordinator has provided cessation referral information (Oregon Quit Line) for staff to give to interested clients.
3. Continue to screen and refer children with feeding/nutritional issues and multiple anomalies for appropriate interventions and services through the CaCoon and Babies First! programs.
4. Develop/implement varnish program for home visiting clients.
5. Home visiting program will educate, advocate, refer and monitor pregnant women for prenatal services and dental health services. A focus of our work thus far has been making sure women are obtaining the prenatal care they need and linking them with dental care.
6. CHD will continue to assume responsibility for administration nursing and behavioral health services to rural Union County schools.
7. CHD will continue strengthening our School-Based Health Center services by conducting outreach to increase utilization and improving services through the addition of new equipment and an Electronic Health Record system.
8. Continue CHD's participation in the U.C. Fit Kids coalition, which is working to address obesity among youth through nutrition and physical activity.
9. Continue with WIC nutrition classes and referral of high risk kids to dietician.
10. Explore and where possible implement nutrition and cooking education using CHD's community kitchen.
11. Explore options for continuing suicide prevention activities.

Program Evaluation

1. Track vital statistic rate for smoking during pregnancy and among youth in schools. TPEP coordinator will share data received via TPEP with relevant CHD staff. Resources include Oregon Tobacco Facts, etc.
2. Track number of varnish applications with home visiting clients through Orchid system.
3. Track efforts to increase the number of pregnant women receiving prenatal care and accessing dental health services.
4. Track progress toward planning and implementing efforts designed to improve nutrition among youth and families.
5. Monitor presence in Union County schools and progress toward improving school-based services.

6. Track youth depression and suicide ideation through Oregon Student Wellness survey.

Current Conditions and Problems for Immunization Program

1. Current Conditions

- a.) Flu activity continues to be low.
- b.) The number of 24-35 month olds covered with the 4:3:1:3:3:1 series was 67% in 2010, which is down from 71% in 2009 and 73% in 2008. The covered rate is still higher than the 2006 and 2007 rate of 57%.
- c.) School exclusion requirements have been positive due to strong partnerships with local schools.
- d.) New Immunization Information System has been implemented and is being utilized by local providers.
- e.) Medical providers in the community have been providing more immunizations, in part due to efforts to create an active local immunization coalition.
- f.) Staffing for immunization outreach and education has been increased with the addition of a part-time public health assistant.

2. Current Problems

- a.) Flu activity in the 2011-2012 season, and thus vaccination activity, has been lower than expected.
- b.) Rate for 24-35 month olds covered with the 4:3:1:3:3:1 series is trending down, and is lower than state requirements and Healthy People objective.
- c.) A limited number of primary care providers offering immunizations creates access barriers.
- d.) Staffing for immunization outreach and education is still extremely limited and is not adequate to address the need in our community.

Program Goals

1. Continue to increase the rate of up-to-date 2 year olds, with the goal of increasing by at least 1%.
2. Increase access to immunizations by pre-school and school-age children.
3. Continue community outreach to increase knowledge regarding immunization and local rates.
4. Support continued utilization of Immunization Information System.

Program Activities

1. Continue meeting with immunization coalition at least quarterly, including reviewing and updating progress on above goals.
2. Coordinate with staff serving rural school districts to conduct vaccine clinics.
3. Hold pre-school immunization clinics at elementary schools and preschools.

Program Evaluation

1. Monitor school exclusion reports for number of children excluded from kindergarten and seventh grade.

2. Monitor countywide AFIX data.
3. Keep coalition minutes in order to monitor goals, activity and progress of coalition.
4. Keep records on dates and topics for in-services with nurses.

Local Public Health Authority Immunization Annual Plan Checklist
July 2012-June 2013
Union County Health Department

LHD staff completing this checklist: Carrie Brogoitti, Kim Knight, Joelene Peasley

State-Supplied Vaccine/IG

- 1. Uses the Oregon Immunization Program (OIP) Vaccine Administration Record (VAR), or a county VAR given prior approval by OIP
- 2. Accurately codes all immunizations according to OIP Vaccine Eligibility Charts
- 3. Pays quarterly Billable Project invoices in timely manner

Vaccine Management & Accountability

- 4. Has an assigned immunization program coordinator
- 5. Uses OIP-approved Standard Operating Procedures for Vaccine Management
- 6. Uses and maintains OIP-acceptable refrigeration equipment
- 7. Uses and maintains OIP-acceptable temperature tracking, calibrated and certified thermometers in every vaccine containing refrigerator & freezer
- 8. Has an OIP-approved vaccine emergency plan
- 9. Complies with OIP vaccine expiration & wastage requirements

Delegate Agencies

- 10. Has one or more delegate agencies: LHD has up-to-date addendum agreements for each site N/A
- 11. Has one or more delegate agencies: LHD has reviewed each site biennially, following OIP guidelines N/A

Vaccine Administration

- 12. Has submitted annual Public Provider Agreement & Provider Profile
- 13. Provides all patients, their parents or guardians with documentation of immunizations received
- 14. Complies with state & federal immunization-related document retention schedules
- 15. Does not impose a charge for the cost of state-supplied vaccines or IG, except for Billable Project or Locally Owned doses
- 16. Does not impose a charge of more than \$15.19 per dose for VFC/317 vaccine
- 17. Does not deny vaccine administration to any VFC or 317-eligible patient due to inability to pay the cost of administration fee, and waives this fee if client is unable to pay

Immunization Rates & Assessments

- 18. Participates in the annual AFIX quality improvement immunization assessment and uses rate data to direct immunization activities

Perinatal Hepatitis B Prevention & Hepatitis B Screening and Documentation

- 19. Provides case management services to all confirmed or suspect HBsAg-positive mother-infant pairs
- 20. Has a process for two-way notification between LHD and community hospital infection control or birthing center staff of pending deliveries by identified HBsAg-positive pregnant women
- 21. Enrolls newborns into case management program & refers mother plus susceptible household & sexual contacts for follow-up care
- 22. [Multnomah County only] provides centralized case management work over the tri-county area of Washington, Clackamas & Multnomah N/A
- 23. Documents & submits to OIP the infant's completion or status of 3-dose Hepatitis B vaccine series by 15 months of age (excluding Washington & Clackamas counties) N/A
- 24. Works with area hospitals to promote the Hepatitis B birth dose vaccine to all infants and Hepatitis B vaccine and IG to affected infants whose mothers are HBsAg positive or whose status is unknown
- 25. Screens all pregnant women receiving prenatal care from public programs for HBsAg status or refers them to other health care providers for the screening
- 26. Works with area hospitals to strengthen hospital-based screening & documentation of all delivering women's hepatitis B serostatus
- 27. If necessary, has an action plan to work with area hospitals to improve HBsAg screening for pregnant women
- 28. Requires and monitors area laboratories & health care providers to promptly report HBsAg-positive pregnant women

Tracking & Recall

- 29. Forecasts shots due for children eligible for immunization services using ALERT IIS
- 30. Cooperates with OIP to recall any patients who were administered sub-potent (mishandled or misadministered) vaccines

WIC/Immunization Integration

- 31. Assists and supports the Oregon Health Authority (OHA) to provide WIC services in compliance with *USDA policy memorandum 2001-7: Immunization Screening and Referral in WIC*

Vaccine Information

- 32. Provides to patients or patient's parent/legal representative a current VIS for each vaccine offered
- 33. Confirms that patients or patient's parent/legal representatives has read or had the VIS explained to them, and answers questions prior to vaccine administration
- 34. Makes VIS available in other languages

Outreach & education

- 35. Designs & implements a minimum of two educational or outreach activities in each fiscal year (July 2012 through June 2013). [Can be designed for parents or private providers and intended to reduce barriers to immunization. This can not include special immunization clinics to school children or for flu prevention.] **Report activity details here:**

Increase administration of Hepatitis B birth doses to all infants and Hepatitis B immune globulin (HIBG) and Hepatitis B vaccine to infants born to HBsAg-positive women, and testing women whose HBsAg status is unknown through at least two educational activities for nurses and/or at birthing classes at Grande Ronde Hospital during fiscal year 2013.

Conduct at least two immunization coalition meetings for Union County immunization providers aimed at increasing the overall vaccination rate of Union County residents during fiscal year 2013.

Surveillance of Vaccine-Preventable Diseases

- 36. Conducts disease surveillance in accordance with *Communicable Disease Administrative Rules*, the *Investigation Guidelines for Modifiable Disease*, the *Public Health Laboratory Users Manual*, and OIP's *Model Standing Orders for Vaccine*

Adverse Events Following Immunizations

- 37. Completes & returns all reportable LHD patient adverse event VAERS report forms to OIP
- 38. Completes the 60-day and/or 1-year follow up report on prior reported adverse events if requested by OIP
- 39. Completes & returns VAERS reports on other adverse events causing death or the need for related medical care, suspected to be directly or indirectly related to vaccine, either from doses administered by the LHD or other providers

School/Facility Immunization Law

- 40. Complies with Oregon School Immunization Law (ORS 433.235-433-284)
 - a. Conducts secondary review of school & children's facility immunization records
 - b. Issues exclusion orders as necessary
 - c. Makes immunizations available in convenient areas and at convenient times
- 41. Completes & submits the required annual Immunization Status Report to OHA by the scheduled deadline
- 42. Covers the cost of mailing/shipping: school exclusion orders to parents, and packets to schools & other facilities

American Recovery & Reinvestment Act (ARRA) Stimulus Funds

- 43. Completes and meets all ARRA (state and federal) reporting requirements **including the ARRA Final Summary Report by November 30, 2011.**

Report submitted? Yes No

Performance Measures

- 44. Meets the following performance measures: [Refer to your 2011 Performance Measure spreadsheet]
 - Yes No: 4th DTaP rate of $\geq 90\%$, or improves the prior year's rate by 1% or more
 - Yes No: Missed Shot rate of $\leq 10\%$, or reduces the prior year's rate by 1% or more
 - Yes No: Correctly codes $\geq 95\%$ of state-supplied vaccines per guidelines in ALERT IIS
 - Yes No: Completes the 3-dose hepatitis B series to $\geq 80\%$ of HBsAg-exposed infants by 15 months of age
 - Yes No: Enters $\geq 80\%$ of vaccine administration data into ALERT IIS within 14 days of administration

Terms & Conditions Particular to LPHA Performance of Immunization Services

- 45. Reimburses OHA for the cost of wasted state-supplied vaccines/IG when required
- 46. Returns at LHD's expense all styrofoam containers shipped from Oregon Immunization Program (and not by McKesson)
- 47. Participates in state-sponsored annual immunization conferences, and uses dedicated OIP-provided funds for at least one person to attend

Reporting Obligations & Periodic Reporting

48. Submits, in timely fashion, the following reports (along with others required & noted elsewhere in this survey):

- Monthly Vaccine Reports (with every vaccine order)
- Vaccine Orders (according to Enhanced Ordering Cycle [EOC] assignment)
- Vaccine inventory via ALERT IIS
- Immunization Status Report
- Annual Progress Report
- Corrective Action Plans for any unsatisfactory responses during triennial review site visits N/A

Non-Compliance Explanation Detail Sheet

Use these table rows to document any checklist statements you were unable to check off or answer with a “Yes”. Be sure to insert the corresponding statement number for each response.

Q. 44 CHD is developing strategies to improve the 4 th DTaP immunization coverage rate by (1) percentage point each year. Since most of the people served by the health department are covered, efforts will be focused on improving the rate among other providers. One strategy we will implement in fiscal year 2013 is educating providers on this issue at an immunization coalition meeting.
Q. 44 CHD was at 90% coded correctly due to coding problems on Flu Pool Vaccine. This problem has been corrected and we are confident the 95% requirement will be met in the future.
Q.

To Submit:

1. Save and print this document for your records
2. Include a copy with Agency Annual Plan
3. Submit as an attachment via e-mail to: Oregon.VFC@state.or.us

Current Conditions and Problems Family Planning Clinics

1. Current Conditions

- a.) CHD has increased the amount and scope of family planning services available in Union County through increased nurse practitioner hours and a new School-Based Health Center at Union School District.
- b.) Ongoing work to link youth with family planning services through two School-Based Health Center located in the county's largest high school and in a rural school district.
- c.) Staffing for family planning outreach and education has been increased with the addition of a part-time public health assistant.

2. Current Problems

- a.) CHD is not adequately positioned to respond to the requirements of state and national health care reform, specifically in the area of Electronic Health Records.
- b.) The number of "Women In Need" decreased in FY 2011 to 1,820 from 2,648 in 2010. This number is more aligned with previous years (1,557 in FY 2008 and 1,867 in 2009). However, despite increasing service availability, the percentage of Women In Need served (42.4%) is still lower than our goal of at least 50%.
- c.) Official reports of teen pregnancy rates vary widely, but anecdotal data suggests teen pregnancy is still an issue for youth in our community. Efforts to facilitate an active teen pregnancy prevention coalition have been unsuccessful, largely due to lack of staffing at CHD to facilitate the coalition and lack of participation by community partners.
- d.) Efforts to increase family planning services to males have not led to significant changes.
- e.) There is limited access to vasectomy services in Union County.
- f.) Staffing for family planning outreach and education is still extremely limited and is not adequate to address the need in our community.

Program Goals

1. Implement an EHR system for CHD's public health services, including family planning and reproductive health services, in FY 2013.
2. Increase the number of vasectomies provided to males in Union County through Title X and CCare during FY 2013.
3. Increase WIN served to 50% or above during FY 2013.
4. Increase percentage of male family planning clients over the next year.
5. Increase outreach and education efforts, particularly to rural areas of Union County.

Program Activities

1. Finalize specific EHR product to be purchased and implemented by CHD.
2. Finalize purchase contract with EHR vendor.
3. Implement EHR product, including the purchase and installation of necessary hardware, training of staff on EHR system, etc.
4. Utilize EHR product.

5. Work with CHD's Tech Services Team to assure that relevant EHR meaningful use criteria are achieved during the 2013 Fiscal Year.
6. Contract with local doctor to provide vasectomy services; train staff on eligibility, service provision, etc.; and develop policies and procedures for providing this service.
7. Use volunteers and/or nursing students for program outreach.
8. Research and implement advertising campaign using materials provided by CCare.
9. Continue providing classes on family planning and STI information in high school health classes.
10. Meet with CHD Alcohol and Drug counselors to discuss possibility of providing family planning and STI classes in their groups.

Program Evaluation

1. EHR system is purchased, implemented, and being effectively utilized for CHD's reproductive health and family planning services.
2. Monitor Ahlers data and the Family Planning Program data review provided by DHS.
3. Brochures/fliers and other outreach materials distributed throughout the county.
4. Evaluate data on the number of vasectomies provided.
5. Review Family Planning Program data provided by DHS.

**FAMILY PLANNING PROGRAM ANNUAL PLAN FOR
COUNTY PUBLIC HEALTH DEPARTMENT**

FY 2013

July 1, 2012 to June 30, 2013

Agency: Center for Human Development (Union County)

Contact: Joelene Peasley RN, BSN, Nursing Supervisor/Family Planning Coordinator

Goal # 1

Problem Statement	Objective(s)	Planned Activities	Evaluation
CHD is not adequately positioned to respond to the requirements of state and national health care reform.	Implement an EHR system for CHD's public health services, including family planning and reproductive health services, by June 30, 2013.	<ul style="list-style-type: none"> *Finalize specific EHR product to be purchased and implemented by CHD. *Finalize purchase contract with EHR vendor. *Implement EHR product, including the purchase and installation of necessary hardware, training of staff on EHR system, etc. *Utilize EHR product. *Work with CHD's Tech Services Team to assure that relevant EHR meaningful use criteria are achieved during the 2013 Fiscal Year. 	EHR system is purchased, implemented, and being effectively utilized for CHD's reproductive health and family planning services.

Goal # 4

Problem Statement	Objective(s)	Planned Activities	Evaluation
CHD experiences challenges in adequately meeting the family planning needs of Union County's rural populations.	Increase the number of Union County residents living outside La Grande that receive family planning/reproductive health services by June 30, 2013.	<ul style="list-style-type: none"> *Work with CHD's community relations coordinator to incorporate family planning/reproductive health-specific outreach to rural areas of Union County into CHD's community relations plan. *Implement components of community relations plan specific to family planning/reproductive health. 	Review of reproductive health/family planning services provided by zip code.

Objectives checklist:

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

3. Progress on Goals / Activities for FY 2012
(Currently in Progress)

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

4. Goal / Objective	5. Progress on Activities
Increase the number of vasectomies provided to males in Union County through Title X and CCare during FY 2012.	CHD has identified a physician who will partner with us to provide vasectomy services, trained and educated staff on the process and their roles, and developed necessary policies and procedures. At this time we are finalizing the contract and will begin offering this service during FY 2012.
Increase WIN served to 50% or above during FY 2012.	In FY 2011 CHD served 42.4% of Union County WIN. This is lower than our goal of 50%. However, based on available data, CHD was successful in increasing the number of WIN served in FY 2011 (771) versus 748 in FY 2010. We are continuing our efforts to work on this goal, which includes the following activities: using volunteers to distribute CCare materials, placing family planning advertisements in local newspapers, training a new nurse and health assistant in counseling and documentation of family planning services at the School-Based Health Center, and providing family planning/STI education for high school juniors and seniors.

C. ENVIRONMENTAL HEALTH

Current Conditions and Problems

1. Current Conditions:
 - a) CHD's employs a 0.75 FTE registered Environmental Health Specialist. During the summer months the Environmental Health Specialist works an additional five hours per week due to increased demand for services when temporary restaurant inspections are at their peak.
 - b) There are more than 140 licensed facilities in Union County providing eating, living, and recreational accommodations.
 - c) There are more than 26 well sites in Union County monitored by Environmental Health following the guidelines of Oregon DEQ and the federal Clean Water Act.
 - d) The Environmental Health Program provides an informational and enforcement role for Oregon's Tobacco Prevention and Education Program.
 - e) The Environmental Health Program works in partnership with the Communicable Disease Program and the Emergency Preparedness Program to educate, investigate, and control countywide foodborne and non-foodborne outbreaks.

2. Current Problems:
 - a) Work flow for the Environmental Health Specialist is complicated by the seasonal changes in the number of temporary restaurants in need of inspection.
 - b) There is a language barrier with certain food service facilities whose primary language is not English and/or who speak very little English.
 - c) Culturally, some food handlers have different views of proper sanitary practices when compared to the guidelines provided by the Oregon Statute (OAR 333-150) and the 2009 FDA Food Code.
 - d) There is limited awareness of local environmental health resources and issues beyond food and water safety focus (such as air quality and asthma).

Program Goals

1. Work toward developing an ongoing solution to the seasonal shifts that impact the work flow of the EHS.
2. Maintain required inspection rates for all facilities, water systems, etc.
3. Explore options for expanding the scope of CHD's environmental health work to address issues such as air quality, asthma, the built environment, etc.

Program Activities

1. Conduct health inspections of all licensed facilities in a timely manner.
2. Conduct inspections of unlicensed facilities as requested by those facilities; certified day care facilities, certified day care homes, jails, and juvenile detention centers.
3. Conduct health inspections of all public schools and Head Start programs.
4. Conduct inspections of licensed temporary restaurants.
5. Properly track all temporary restaurant facilities in Union County.

6. Track all newly issued food handler cards.
7. Maintain scheduled testing and licensing for food handlers in Union County.
8. Perform investigations prompted by citizen complaints on potential health hazards in licensed facilities.
9. Make arrangement with a person who speaks associated languages to help educate the limited English speaking food handlers in proper food handling techniques and to pass the examination for the food handler card.
10. Monitor and assure that Union County's drinking water is safe by providing and maintaining sanitary survey inspections, regulatory assistance and training, compliance assurance, emergency response planning, investigation and response on contamination incidents.
11. Establish protocol for certain telephone inquiries relating to mold, radon, and other environmental health requests.
12. Provide accurate summarizations for the 2012 Licensed Facility Statistics Report.
13. Explore options for increasing CHD's role in environmental health, especially as it relates to health indicators such as asthma that impact Union County.

Program Evaluation

1. Review data from the Phoenix database system to ensure completeness and accuracy.
2. Inspection scores of low scoring restaurants will improve.
3. Increase in food handler cards issued to individuals with English as a second language.
4. Increase in food handler cards issued to all food service workers.
5. Increased engagement in broader environmental health issues.

D. HEALTH STATISTICS

Current Conditions and Problems

1. Current Conditions

- a.) Union County Public Health currently tracks health data in the following state public health systems: ORCHIDS, ALERT, Ahlers, EDRS, Phoenix Database System, and Fusion.
- b.) We also collect service, demographic, clinical and billing data in a CHD system called ECHO.
- c.) CHD reviews health statistics from various data sources compiled by the Center for Health Statistics, the State Office of Rural Health, and others.
- d.) CHD and local funeral homes are fully transitioned to the EDRS.
- e.) CHD works closely with Union County providers of childhood immunizations to encourage the entering immunization data in ALERT.
- f.) Union County was awarded a grant from the state to develop and implement new technology that allows for the transfer of immunization information between our Electronic Health Record and the new ALERT Immunization Information System in real time.
- g.) General community health and issue-specific assessments of current conditions and problems that are not captured in state/federal data sources are conducted by various entities.
- h.) CHD completes its responsibilities in filing certified death certificates in one to two days.

2. Current Problems

- a.) While much progress has been made in the area of data entry by local immunization providers, there are always some that are challenged to comply and constant education must occur.
- b.) Information on health issues that are occurring locally can be challenging due to delays in data being available from the state, data not being available due to sample sizes being too small, and changes in data collection instruments (state youth surveys, census, etc.).
- c.) Up to this point assessment activities by various community groups have not been extremely coordinated, which results in a number of different assessment activities and reports being conducted. Public health accreditation will require a more systematic assessment of the local community.

Program Goals

1. Enroll physicians with biometric signature for EDRS as requested.
2. Provide education and support related to ALERT data entry.
3. Conduct regular assessments so accurate, timely local data is available.

Program Activities

1. Continue reporting data to state per various program requirements.
2. Monitor state reports for accuracy of data
3. Work with local physicians to enroll E-signatures when requested.
4. Continue immunization coalition to educate local providers on the importance of immunization data collection and data entry in to ALERT system.
5. Work with partners to conduct local needs assessment activities and increase coordinated activities.

Program Evaluation

1. All interested physicians will be enrolled with electronic signatures.
2. Monitor site review results to determine needed areas for improvement in data collection.
3. Monitor data reports for accuracy of data.
4. Immunization coalition meetings held at least quarterly.
5. Local needs assessments conducted on a regular basis.

E. INFORMATION AND REFERRAL

Current Conditions and Problems

1. Current Conditions
 - a.) CHD Public Health has a Web site (www.chdinc.org) that is updated regularly with information on the programs and services offered, information on current health issues, contact information, and opportunities for public input.
 - b.) CHD is developing a presence on social networking sites like Facebook and Twitter to share more information about our work with the public.
 - c.) Nurses respond to inquiries and concerns from the public on specific issues on a case by case basis, also providing written educational material/brochures as appropriate.
 - d.) Periodically public health staff writes Community Comments in the local newspaper addressing various health topics.
 - e.) CHD staff work with the media and county staff on disseminating health information to the public in a timely and targeted manner when needed, as during H1N1, West Nile, and Pertussis outbreaks.
 - f.) CHD is in the process of developing a community relations plan aimed (in part) at increasing our information and referral efforts.
 - g.) In 2011 a part-time public health assistant position was added to CHD's public health team to help increase work in the area of information and referral.
2. Current Problems
 - a.) Delivery of population-based prevention messages and interventions is extremely difficult due to lack of resources. Our ability to serve older adults, for example, is limited to activities such as flu shots, because we do not have revenue streams specific to this population.
 - b.) Community assessments reveal that more staff time is needed to push health education material to the public, especially to partner organizations and un/underserved communities.
 - c.) Despite the addition of new staff and community outreach planning efforts, there is still very limited capacity to conduct information and referral activities to the level that is needed.

Program Goals

1. Keep community updated on current relevant public health issues.
2. Push information to segments of the community and partners serving them to increase community awareness of local issues related to underutilized services, such as childhood immunizations and family planning, and diseases like Chlamydia that are experiencing upward trends.
3. Explore approaches to expanding the reach of our services to those groups and individuals we face challenges in serving.

Program Activities

1. Continue to keep Web site and social networking sites updated with current program and local health information.
2. Identify and have staff disseminate health information to relevant partners.
3. Work with the local newspaper, Union County staff, and vector control program in disseminating timely public health information.
4. Explore partnerships with organizations providing services to groups who could benefit from additional services.
5. Complete and implement public health components of community relations plan

Program Evaluation

1. Monitor updates of Web site.
2. Monitor health articles in the paper.
3. Monitor partnership development and collaborative efforts with other organizations and groups.
4. Monitor progress on public health-related community outreach plan activities.

F. Public Health Emergency Preparedness

Current Conditions and Problems

3. Current Conditions

- a.) CHD) has a 0.50 FTE emergency preparedness coordinator working on emergency preparedness in our community.
- b.) The preparedness coordinator is highly trained and has been with CHD for several years, which has led to strong connections with local partners.
- c.) We have developed solid working relationships with other important community stakeholders including the Union County emergency manager and the local hospital. This includes newly-implemented monthly meetings between CHD, the county emergency manager, and hospital emergency response coordinator. The emergency preparedness coordinator is also working to form an emergency services coalition in accordance with Program Element 12.
- d.) CHD has used real events like our flu clinics to practice our response plans along with conducting additional exercises as needed.
- e.) CHD utilizes HAN and has had a high participation rate in state and regionally-initiated drills related to HAN and satellite phones.
- f.) Recently CHD staff has completed all necessary ICS, CD, and HAN trainings. A coordinated system is in place to ensure that new staff receives this training as well.

4. Current Problems

- a.) Preparedness plans are in place but many need updates. This includes the need to review existing documents and procedures related to isolation and quarantine and working with legal counsel to ensure they are adequate.
- b.) We have not had the opportunity to develop our plans related to serving the needs vulnerable populations and have not utilized all of the internal resources we have to do this (i.e. staff working with developmentally disabled and mentally ill clients).
- c.) The large geography and widely spread population in Union County raises concerns about our dispensing prophylactic medication or vaccine within 48 hours if needed.
- d.) Testing of 24/7 response systems has not been done as often as we would like due to changes in procedures and staffing.
- e.) CHD previously served as the Regional Lead Agency for Region 9 until this function was taken back by the state. The loss of this role is likely to reduce valuable connections CHD had with local and regional partners.

Program Goals

1. CHD staff is adequately trained in appropriate areas of emergency response.
2. Plans and systems are in place and up-to-date to ensure effective respond to emergencies, including vulnerable populations and mass dispensing plans.

3. Strengthen integration of emergency preparedness, communicable disease, environmental health, and health care preparedness to support effective response efforts.
4. Testing of 24/7 system occurs on a regular basis.

Program Activities

1. Continue participating in regular preparedness meetings and in Healthcare Preparedness Coalition activities.
2. Develop plans for serving vulnerable populations. Engage staff working with developmentally disabled and mental health communities in this process.
3. Develop feasible mass dispensing plan.
4. Conduct testing of 24/7 response system monthly.
5. Update all existing plans and ensure that all other necessary plans are created and exercised if appropriate.

Program Evaluation

1. Completed vulnerable populations and mass dispensing plans.
2. Response system testing record.
3. Review of plans for updates and completeness.

IV. Additional Requirements

Organizational Chart: An organizational chart for the Center for Human Development, Inc. is attached.

Board of Health: Center for Human Development, Inc. (CHD) is a nonprofit corporation responsible to a Board of Directors. Union County contracts with CHD to be the Public Health Authority, so CHD's Board serves as the local Board of Health. The Board is comprised of community members who meet monthly. A CHD staff member also serves as a representative to the Board. The Board is ultimately responsible for the agency, while delegating the executive function to CHD's Administrative Council (described below). The Board of Directors oversees the finances, assets and affairs of the organization.

The Administrative Council is responsible for the executive functions of the organization including: strategic, financial, human resources, legal, community relations, organizational structure, information, and clinical leadership. The public health administrator is a member of and accountable to this team with responsibility for the functions identified in the statutes and administrative rules.

Public Health Advisory Board

The Union County Human Services Advisory Committee is a group of community members appointed by the Union County Commissioners. The Commissioners utilize the Committee as a means of monitoring CHD's work on their behalf. The Committee provides assistance with mental health and public health programs by offering guidance and support to Center for Human Development administrators.

Senate Bill 555 CCF Coordination

The Local Public Health Authority (LPHA), CHD, is not the governing body that oversees the local Commission on Children and Families (CCF). The LPHA and the local CCF do engage in a number of coordinating activities. A member of CHD's Administrative Council sits on the board of the CCF, and currently this is the public health administrator. The director of the CCF regularly attends the Union County Health and Human Services Advisory Committee, the committee responsible for serving as advisors to the County Commissioners on the status of public health and mental health services in the county and monitoring the county contract with the CHD. In addition, CHD staff sits on various CCF committees, and staff of both the LPHA and the CCF participates in many joint activities throughout the year.

V. Unmet needs

CHD has identified the following areas of unmet need that we are not currently able to address due to lack of available resources:

- **Outreach and Education:** Over the past year the number of people accessing CHD's services has been decreasing in areas where the need is increasing or unchanged, such as family planning, WIC and the La Grande School-Based Health Center. We attribute this to a lack of resources to conduct outreach and provide education about our services and about public health in general. We need dedicated resources to support outreach efforts.
- **Accreditation:** CHD is excited about the prospect of becoming an accredited public health department, and fortunately we have received funding and an AmeriCorps VISTA member to help prepare our application. Even with these resources, it is difficult to dedicate the amount of staff time that is needed for accreditation and there are concerns about how ongoing activities required for accreditation will be sustained after the one-time resources are gone.
- **Population-Based Prevention Efforts:** Aside from very specific and prescribed funds from the state, our organization struggles with finding resources to dedicate to "upstream" public health efforts aimed at addressing issues at the population level.
- **Environmental Health:** We have not been able to address environmental health issues beyond our water or facility inspection programs. Efforts such as addressing obesity through the built environment, addressing asthma through air quality monitoring, looking at climate change and its potential impact on our community, and/or decreasing childhood lead levels through lead education/intervention programs are not possible because we do not have the resources.
- **Access to Care:** Primary care is limited in our county due to few primary care providers, high uninsured rates, and lack of resources on the part of individuals to pay for care.
- **Chronic Disease Prevention:** Chronic diseases are of significant concern in the County, yet there are not enough chronic disease prevention or public health intervention programs.
- **Childhood Asthma:** High childhood asthma rates and poorly treated asthma are significant issues in Union County that are not being adequately addressed.
- **Older Adult Services:** There is a large older population in Union County but preventive and other general public health services that address their needs are limited.
- **Nutrition Education:** Data raises serious concerns about the nutrition of Union County residents being very poor yet there are limited services to help populations who are not involved with WIC in this area.

VI. Budget

**Center for Human Development, Inc.
Projected Revenue
2012-2013**

Supported Program Element (PE)	Projected Award Amount Based on 2011-2012 Award
PE 01: State Support for Public Health	\$28,908
PE 12: Public Health Emergency Preparedness	\$71,869
PE 13: Tobacco Prevention and Education	\$56,512
PE 40: Women, Infants and Children	\$141,388
PE 41: Family Planning	\$14,605
PE 42: MCH-Title V – Flexible Funds	\$12,284
PE 42: MCH-Title V – Child and Adolescent Health	\$5,265
PE 42: MCH/Perinatal Health – General Fund	\$1,853
PE 42: MCH/Child and Adolescent Health – General Fund	\$3,478
PE 42: Babies First	\$5,869
PE 43: Immunization Special Payments	\$11,835
PE 44: School Based Health Centers	\$82,000

A copy of the Local Public Health Authority public health budget can be obtained using the following contact information.

Rico Weber
Fiscal Coordinator
Center for Human Development, Inc.
1100 K Avenue
La Grande, OR 97850
541-962-8877
www.chdinc.org

VII. Minimum Standards

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

Organization

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

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

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

Control of Communicable Diseases

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

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

Environmental Health

47. Yes No ___ Food service facilities are licensed and inspected as required by Chapter 333 Division 12.
48. Yes No ___ Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.
49. Yes No ___ Training in first aid for choking is available for food service workers.
50. Yes No ___ Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided.
51. Yes No ___ Each drinking water system conducts water quality monitoring and maintains testing frequencies based on the size and classification of system.
52. Yes No ___ Each drinking water system is monitored for compliance with applicable standards based on system size, type, and epidemiological risk.
53. Yes No ___ Compliance assistance is provided to public water systems that violate requirements.
54. Yes No ___ All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken.
55. Yes No ___ A written plan exists for responding to emergencies involving public water systems.

56. Yes No Information for developing a safe water supply is available to people using on-site individual wells and springs.
57. Yes No A program exists to monitor, issue permits, and inspect on-site sewage disposal systems.
58. Yes No Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.
59. Yes No School and public facilities food service operations are inspected for health and safety risks.
60. Yes No Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12.
61. Yes No A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste.
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 (Not Applicable)
75. Yes No Clients identified at nutritional risk are provided with or referred for appropriate interventions.
76. Yes No Culturally and linguistically appropriate nutritional education and promotion materials and methods are integrated within programs.
77. Yes No Local health department supports continuing education and training of staff to provide effective nutritional education.

Older Adult Health

78. Yes No Health department provides or refers to services that promote detecting chronic diseases and preventing their complications.
79. Yes No A mechanism exists for intervening where there is reported elder abuse or neglect.
80. Yes No Health department maintains a current list of resources and refers for medical care, mental health, transportation, nutritional services, financial services, rehabilitation services, social services, and substance abuse services.

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

Parent and Child Health

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

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

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

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

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

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

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

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

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

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

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

Primary Health Care

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

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

95. Yes No The local health department advocates for individuals who are prevented from receiving timely and adequate primary health care.
96. Yes No Primary health care services are provided directly or by referral.
97. Yes No The local health department promotes primary health care that is culturally and linguistically appropriate for community members.
98. Yes No The local health department advocates for data collection and analysis for development of population based prevention strategies.

Cultural Competency

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

Health Department Personnel Qualifications

Local health department Health Administrator minimum qualifications:

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

Answer the following questions:

Administrator name: Carrie Brogoitti

- | | |
|---|---------------------|
| Does the Administrator have a Bachelor degree? | Yes <u>X</u> No ___ |
| Does the Administrator have at least 3 years experience in public health or a related field? | Yes <u>X</u> No ___ |
| Has the Administrator taken a graduate level course in biostatistics? | Yes <u>X</u> No ___ |
| Has the Administrator taken a graduate level course in epidemiology? | Yes <u>X</u> No ___ |
| Has the Administrator taken a graduate level course in environmental health? | Yes <u>X</u> No ___ |
| Has the Administrator taken a graduate level course in health services administration? | Yes <u>X</u> No ___ |
| Has the Administrator taken a graduate level course in social and behavioral sciences relevant to public health problems? | Yes <u>X</u> No ___ |

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

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

AND

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

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

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

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

OR

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

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

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

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

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

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.

Center for Human Development, Inc.
Local Public Health Authority

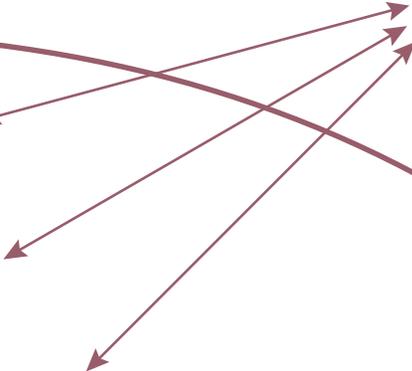
Union
County

January 15, 2012
Date

Center for Human Development, Inc. Organizational Structure

- County Commissioners
- Regulators
- Stakeholders
- Partners
- Community

Board of Directors



ADMINISTRATIVE COUNCIL

Dwight Dill
Mental Health Director

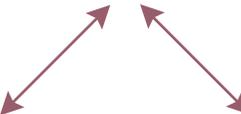
Susie Cederholm
HR Coordinator

Roni Wood
Operations Coordinator

Andi Walsh Sexton
Community Relations/Grant Coordinator

Rico Weber
Financial Coordinator

Carrie Brogoitti
Public Health Administrator



CROSS-TEAM COMMITTEES

- FisComm
- Personnel
- Facility
- Operations
- Ad Hoc Committees

TEAMS

- Behavioral Health/Rehab
- Enhanced Care Services
- Developmental Disabilities
- Veterans Services
- Public Health Services
- Home Visiting/WIC
- Business Services/Accounting
- Prevention
- Tech Services



“working for healthy communities”