



COLUMBIA HEALTH DISTRICT

Public Health Authority 9 Columbia River Community Hospital

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April 24, 2008

Tom Engle
Office of Community Liaison
DHS Public Health Services
800 NE Oregon St.
Portland, Oregon 97232

Dear Tom:

Please accept this letter and the attachments as our Columbia County Annual Plan update for fiscal year 2008-2009. Columbia Health District is mid-cycle this year and so we are submitting an update only. The following components have been updated:

- Executive summary
- Assessment
- Nutrition Education Plan
- Family Planning
- MCH plan update
- Environmental Health
- Babies First/CaCoon
- Immunization
- Tobacco Prevention
- Organizational chart
- Minimum standards indicators

State public health has defined July 2008 as the timeline for receiving projected revenue sheets from the state. At that time, Columbia Health District will complete the defined fiscal process. Our fiscal manager is Thalia Piano. Her contact information is tpiano@chdpublichealth.com. Her telephone information is (503)397-4651.

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.

For Columbia Health District Public Health Authority

_____ Gary Heide, Chair	_____ date
_____ Laura Tomanka, Vice Chair	_____
_____ Jay Tappan, Secretary	_____
_____ Alice Dorschler, Treasurer	_____
_____ David Schmor	_____

Executive Summary

The local public health plan for Columbia County and its updates can be found at www.oregon.gov/dhs/ph/lhd/reference.shtml. This year the county submits an update to the comprehensive plan. The requirement for a local public health annual plan is in statute ORS 431.375-431.385 and ORS 431.416. and Oregon Administrative Rule (OAR) Chapter 333, Division 14. ORS 431.375 defines policy for local public health services. Policy states that the public health system in Oregon is to provide basic public health services, that counties can provide or contract responsibility or relinquish these services to the state, and that all public funds utilized for public health services must be approved by the local public health authority.

The Minimum Standards for Local Health Departments states “ In the state of Oregon, responsibility for public health protection is shared between the state Department of Human Services, health services section and the local public health authorities. Local and state agencies perform different tasks. They have unique, but complimentary roles and they rely on one another to make the public health system work effectively.” The community should be able to rely upon the partnership between the state and local government.

Were there unlimited amounts of funding, one might expect that most public health needs would be met. The State of Oregon allots only 2.5% of its DHS budget to public health functions at the state and local levels combined. Those funds that reach the local level are for specific programs. In Columbia County, those dollars supplement federal dollars to provide home visits to high risk infants and children, supplement federal dollars that help fund emergency preparedness and communicable disease epidemiological response, and supplement federal dollars that help provide prenatal care for women in need. The state also provides funding to school-based health centers. St. Helen’s school district in Columbia County receives funding that is passed through the local health department for health care to some elementary school students in the district. January-June of 2008 we have had community planning dollars to establish more School Based Health Centers in our county. We aren’t completed with the process yet but there is the possibility we may establish two new sites.

The services delivered locally are restricted by funding streams that are provided by federal and state dollars. Those services are effected by formulas developed at the state level by a state/local partnership. Most funding formulas are developed with representation from Conference of Local Health Officials.

ORS 431.380 states that the distribution of funds to the local public health authority are to be used for public health services.

ORS 431.385 states that the local annual plan shall be submitted annually to DHS, that DHS shall review and approve/disapprove the plan, and that there shall be an appeals process if the plan is disapproved. It also states that the local Commission on Children and Families shall reference the public health plan in its comprehensive plan (ORS 417.775).

The local public health authority duties according to ORS 431.416 are to:

1. Administer and enforce the rules of the local public health authority and the public health rules and law of DHS
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:
 - a. epidemiology and control of preventable diseases and disorders
 - a. parent and child health services, including family planning clinics)ORS 435.205)

- b. collection and reporting of health statistics
- c. health information and referral
- d. environmental health services

These services are further defined in OAR Chapter 333, Division 14 as well as the Minimum Standards for Local Health Departments document.

The minimum standards document is designed to include elements of the essential public health services as identified by the American Public Health Association publication, Public Health in America, 1994. The document identifies two key concepts: The first is that public health:

- 1. prevents epidemics and the spread of disease
- 2. protects against environmental hazards
- 3. prevents injuries
- 4. promotes and encourages health behaviors
- 5. responds to disasters and communities in the recovery phase
- 6. assures the quality and accessibility of health services

The second key concept is the ten essential public health services that are actually quite limited in Oregon rural counties. Lack of funds can be restrictive in meeting public health needs. Sufficient resources to achieve these standards are necessary for compliance.

The action plan for this year will focus on current programs and their goals, objectives, actions, and evaluation.

ASSESSMENT

Columbia County is 687 square miles of picturesque scenery. The Columbia River defines the northern and eastern borders of the county. The terrain is mountainous with winding two lane roads. Columbia County’s history is agriculture and timber oriented. Most of the agricultural land has been sold to developers and no longer produces fruits and vegetables. The timber industry is also decreasing. Housing development has replaced the farms. Family wage jobs are becoming more scarce. Commuting to the Portland metro area is becoming the norm. There is not a public transportation system that allows people to commute by train or bus to the metro area to work.

DEMOGRAPHIC CHARTS

Other demographic characteristics about Columbia County include:

Geography: Northwest Oregon, 687 square miles.

Average Temperature: January 39E July 68.4E

Annual Precipitation: 44.6"

County 57.19% 27,856 28,852 31,858

Unincorporated

County

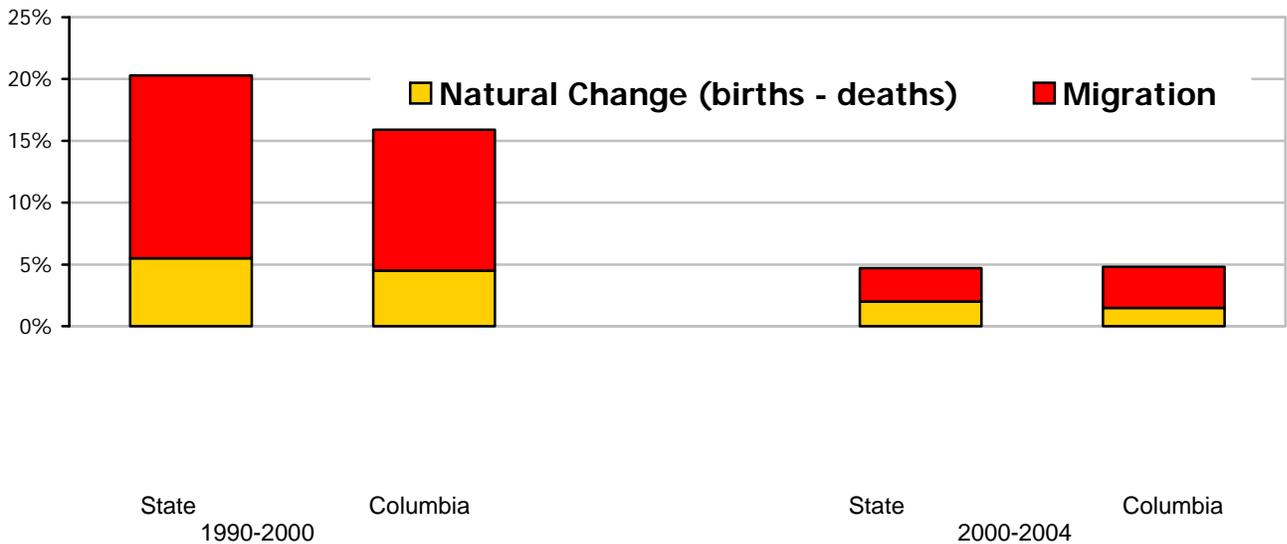
42.80% 20,098 21,500 23,742

COUNTY TOTAL 100.00% 48,641 50,352 55,600

Note: Based on the assumption of a continuing 20 year trend in population proportion.

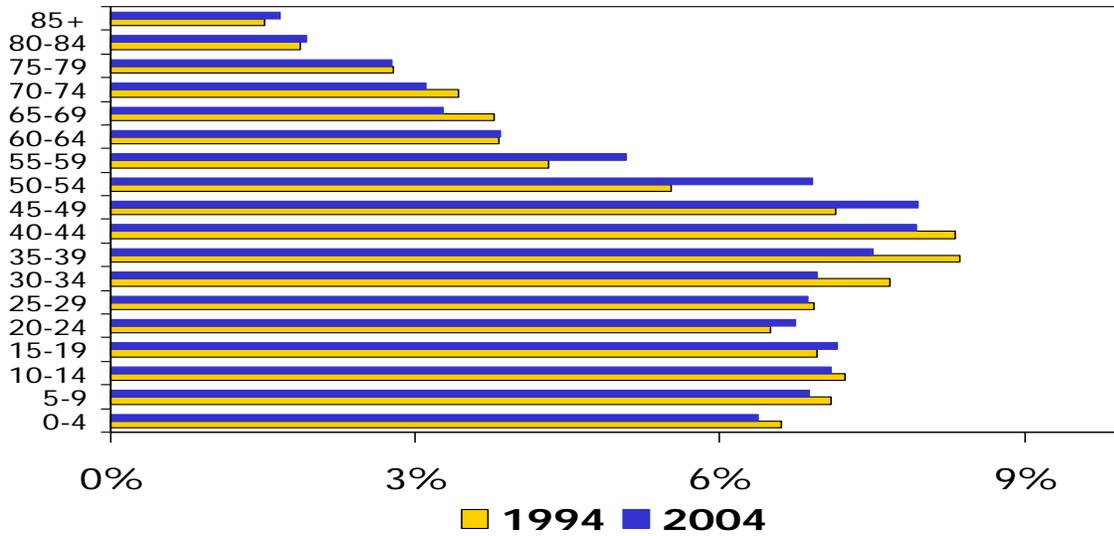
The information is from Population Research Center, College of Urban and Public Affairs, Portland State University,

Percent and source of change in population 1990-2000 & 2000-2004

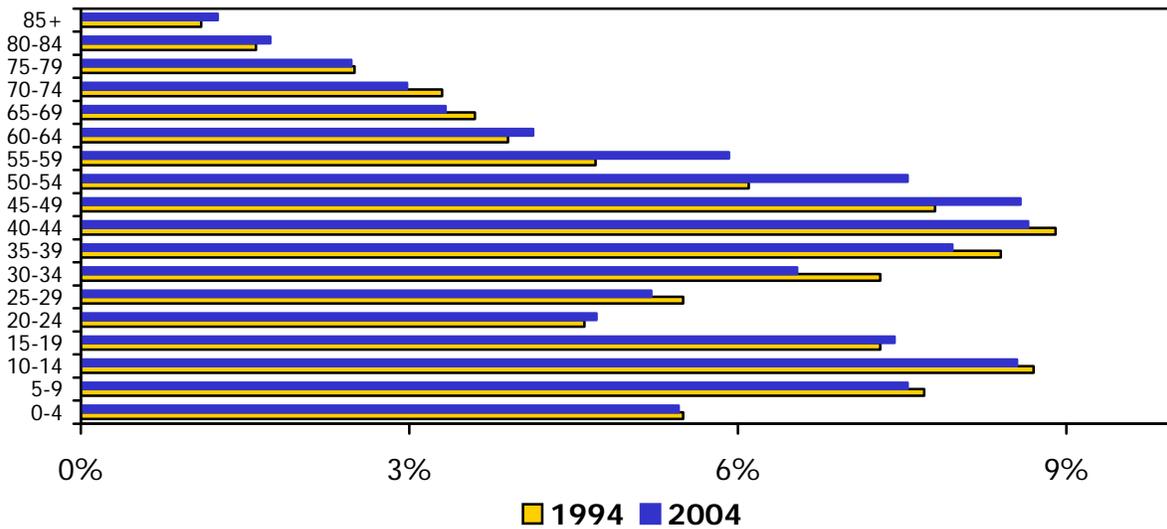


Population by age, 1994 and 2004

Oregon

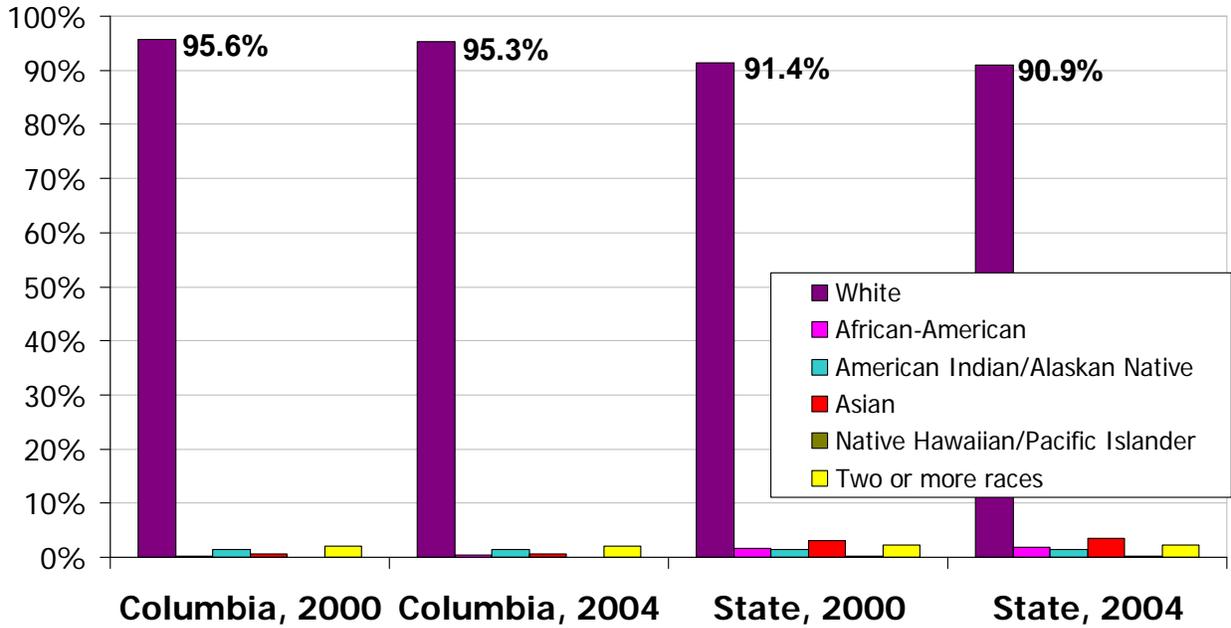


Columbia County

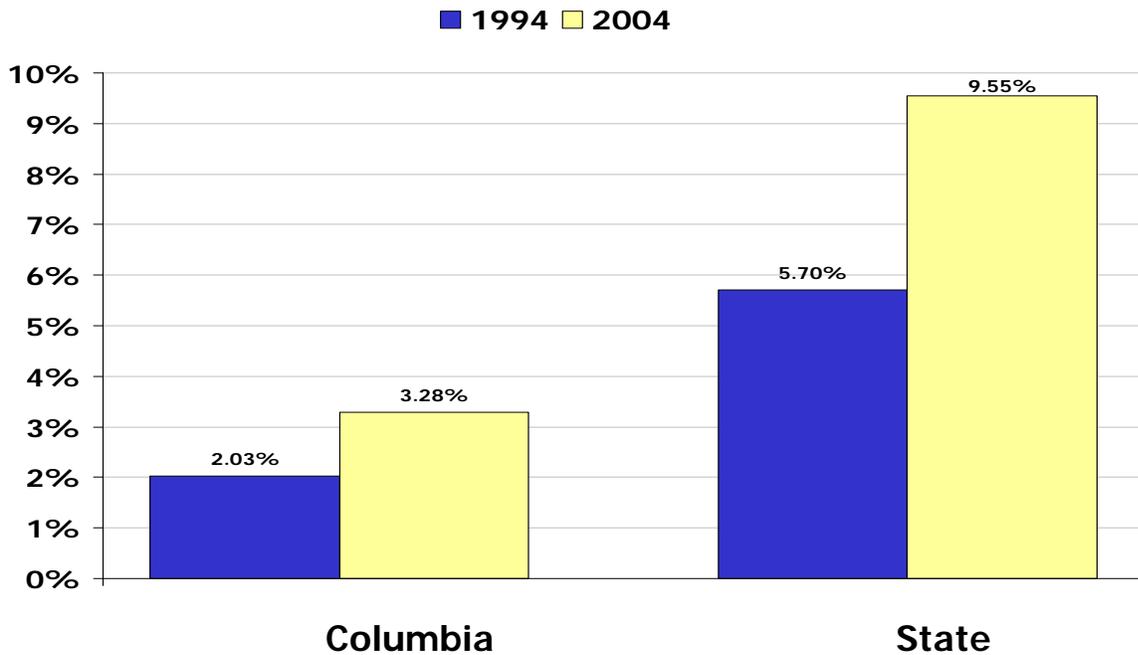


Population by race, 2000 and 2004

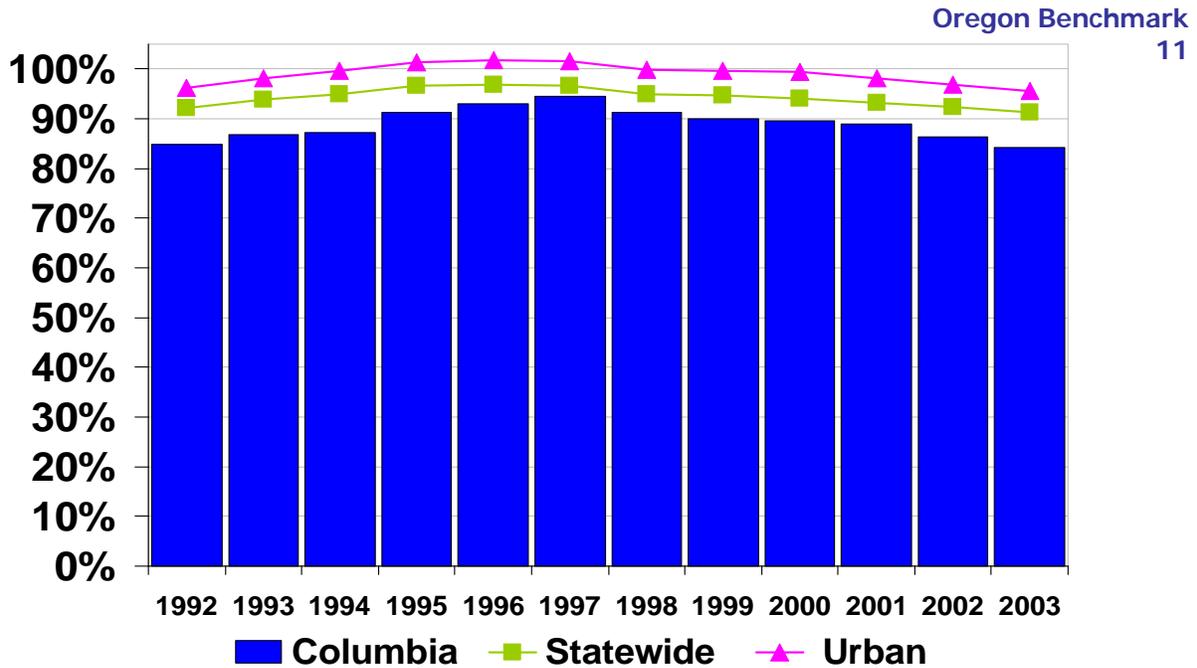
(Hispanics, an ethnic group, are represented in all racial categories).



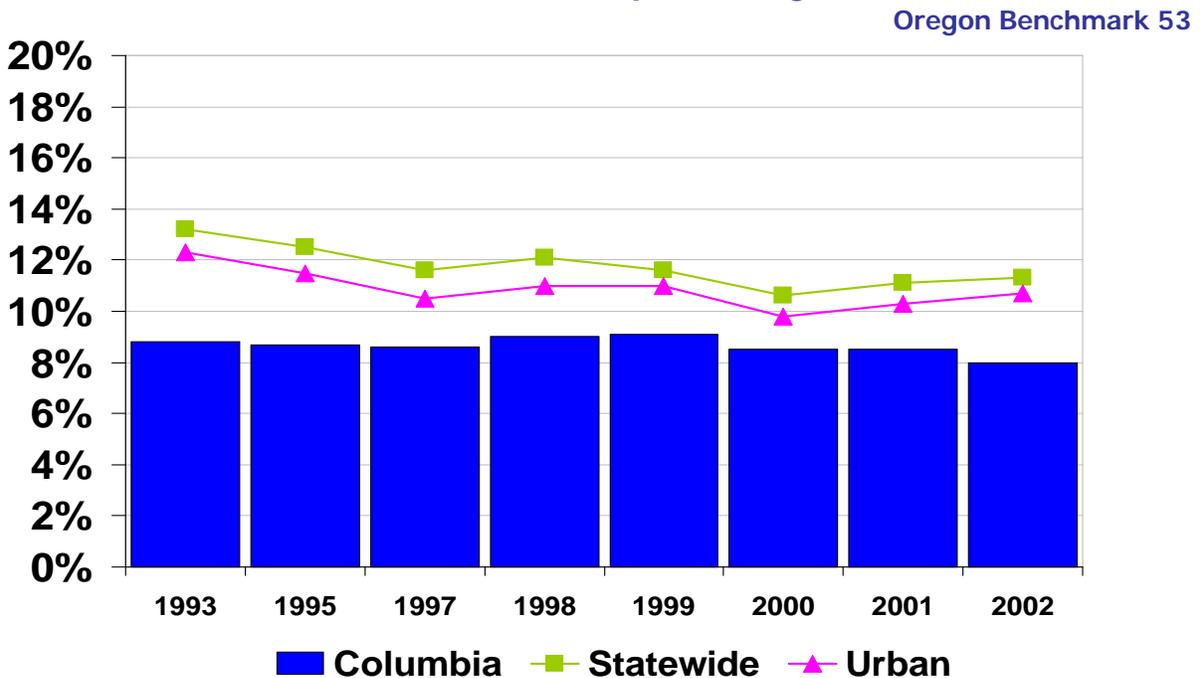
Percent that is Hispanic, 1994 & 2004



Per capita personal income as percent of the U.S. per capita income



Percent of population with incomes below 100% of the federal poverty level



NUMBER OF PERSONS ELIGIBLE FOR MEDICAID AND FOOD STAMPS COLUMBIA COUNTY

Date Number Eligible for Medicaid & Food Stamps

Oct. 2001	3,477	3,851
Oct. 2002	3,944	4,337
Oct. 2003	3,614	4,839
Oct. 2004	4,513	5,188
Oct. 2006	4,514	5,404

Information provided by the Department of Human Services

SOURCES

Child Welfare, Homelessness, Poverty, Self Sufficiency

Department of Human Services, Oregon Children, Adults and Families, Data Charts, October, 2005

http://www.oregon.gov/DHS/assistance/data/caf_charts/102005.pdf

www.dhs.state.or.us/abuse/publications/childabusereports.htm

Community Action Team

<http://www.cat-team.org/>

PUBLIC HEALTH AND THE COMMUNITY

Public health services as well as the authority for enforcement are provided by the Columbia Health District in an intergovernmental agreement between Columbia County and the Columbia Health District. The District, a public non-profit with a publicly elected board, provides the public health services required in ORS 431.375 - 431.385 and ORS 431.416 and rule (Chapter 333, Division 14). Mental health services are contracted out from the county to a private, non-profit agency and the county retains the authority. Columbia Community Mental Health agency subcontracts services to other private, non-profit entities. The Children and Families Commission in Columbia County is a department within county government. State DHS services (i.e. self sufficiency services, food stamps, and senior and disabled services) are provided by state staff in yet another agency..

We continue to participate with the Commission on Children and Families by having staff on the executive board of the Commission. We participate in the early childhood planning efforts of the Commission. We participate in the tough decisions that the Commission is having to make as the dollars decrease in their agency as well.

Involvement of staff in the local communities takes many forms. The staff each participate in committees linked to their role in the agency. The following are committees that CHD staff participate in the local communities:

Columbia County mental health advisory committee

- Columbia County local alcohol and drug prevention committee
- Head Start advisory committee
- Healthy Start advisory committee
- Early intervention advisory committee
- District attorney's MDT committee
- CASA advisory committee
- St. Helens school-based health center advisory board

- Local Commission on Children and Families
- Columbia County emergency planning association
- Medical reserve corps
- Homeland security emergency planning committee
- Public health foundation of Columbia County

Regionally, staff members are involved in the Northwest Region I regional emergency planning committee and Six-County City Readiness Initiative.

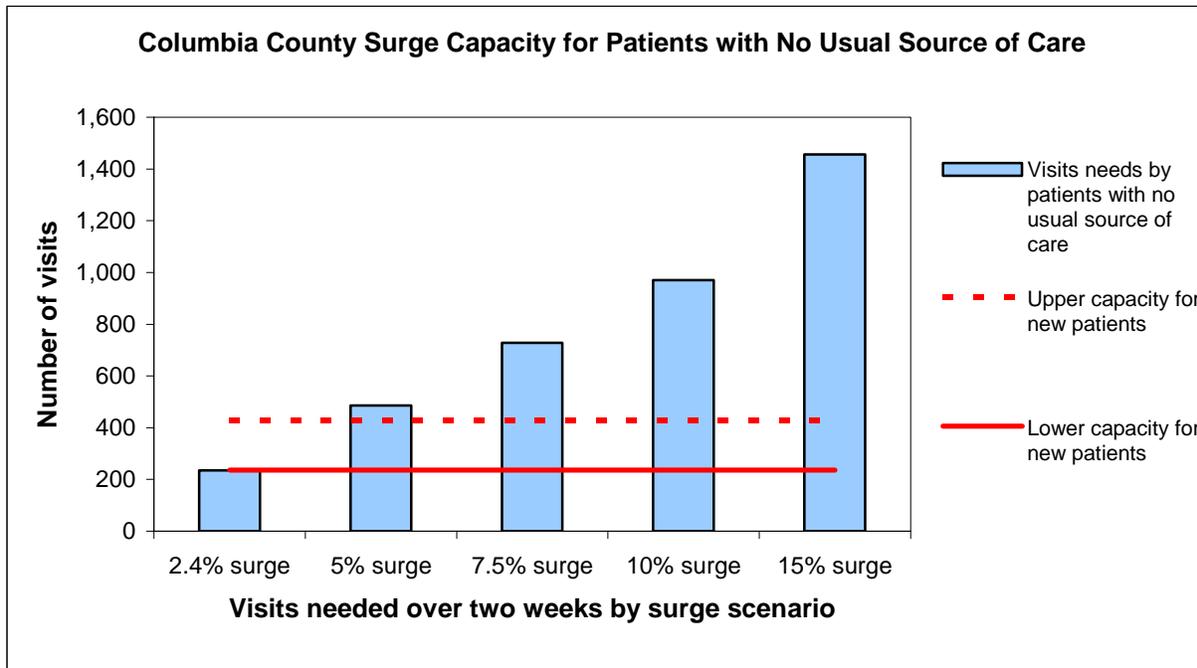
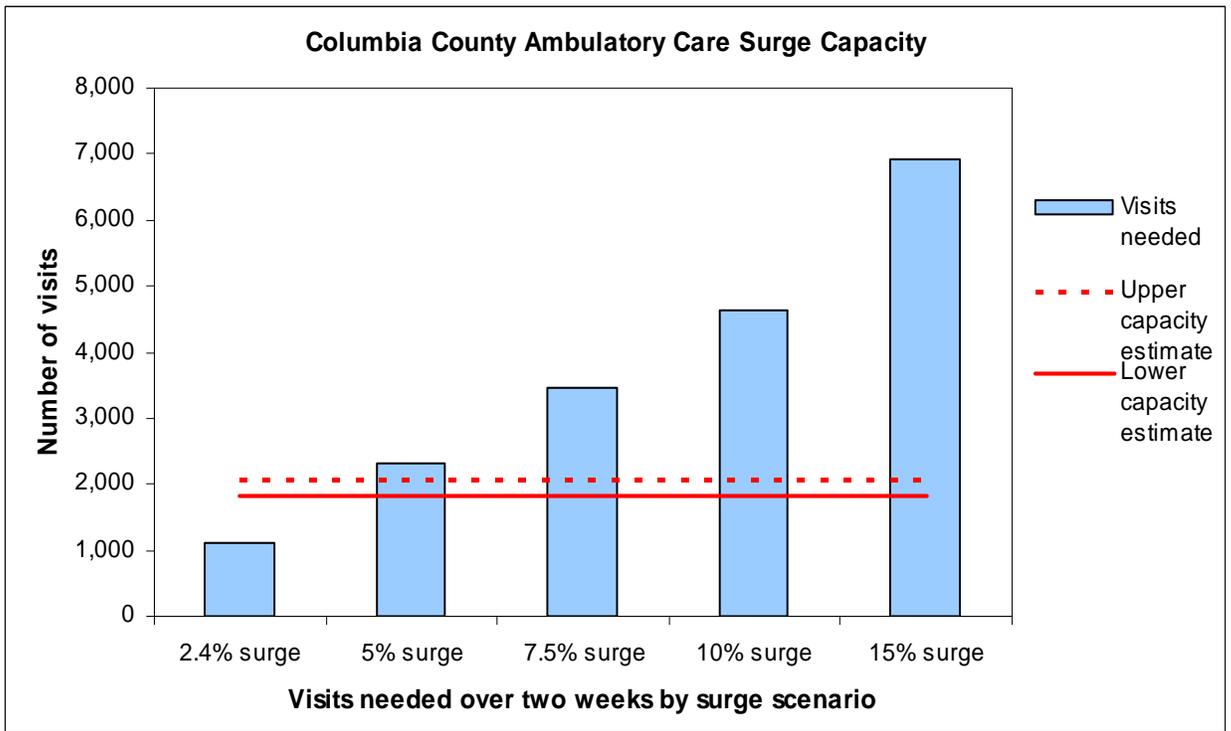
In the past year, Columbia Health District planned and executed four successful PODS to dispense flu vaccine and practice our emergency readiness. We planned a fifth POD, but were unable to accomplish that because of the real emergency flooding in Vernonia. In April 2008 staff was stretched to the maximum because of an active TB case in a public institution. This case will impact CHD into the upcoming fiscal year. The Columbia County Medical Reserve Corps had a role in our Flu PODs and also the TB case. This is a highly successful mobilization for us.

Columbia County, according to the state of Oregon's Area of Unmet Healthcare Needs evaluation, is the most medically under served county in Oregon. The St. Helen's Hospital closed during the 1990's federal reimbursement cutbacks. About 400 hospitals closed across the nation during that time. Columbia Health District has been working to build a critical access hospital in the county. In 2004 the district passed a referendum to establish a new tax rate. Since that time, the district has hired an architectural firm, a project management firm and had a second feasibility study. Currently, the district is looking at property and hospital design.

We have only 10 full-time equivalent physicians (only five of those are full-time) in the entire county. The closest hospital is 30 miles away currently. There is one urgent care clinic operating in St. Helens eight hours per day six days a week.

If an epidemic were to occur, our county would be behind the curve in caring for the population, surveillance, control activities, and prevention. Although our link with local health care providers and veterinarians has improved with the emergency communications work we are doing through the Federal bioterrorism grant, we fight an uphill battle because we lack basic infrastructure. If an epidemic were to occur and the county needed to expand health care, it would be difficult for the current providers to scale up to meet the demand. A recent study bears this out.

The Office for Oregon Health Policy and Research prepared a report entitled: Ambulatory Surge Capacity in Northwest Oregon in May 2006. The following charts are from that report;



Emergency Planning

Columbia County has a newly created Homeland Security Emergency Planning Committee. It will have representation from public and private entities throughout the county. Columbia Health District Public Health Authority has been included in the membership. Even though Public Health provides no primary care services, Public Health's role is often seen as medical by the emergency planners because there is no other entity to fill this role. A hospital would be a more appropriate source to rely on for surge capacity and could provide the needed expertise and be a great planning partner. Multnomah and Washington counties are the two major health care access points for Columbia County citizens. Multnomah, Washington, Clackamas, Clark (Washington state), and Columbia counties are working on a regional memorandum of understanding, exercises and medical reserve corps for emergencies.

The current public health emergency response system is linked to the 9-1-1 system in the county. Public health during the past year has worked to implement a call-out system that is integrated with the rest of the emergency infrastructure in the county. Public health will now be given notice of all biohazard 1 and biohazard 2 events by 9-1-1.

The 9-1-1 district has a community alert network system (CAN) that can be used by public health to notify residents of emergencies. Public Health could notify water systems' users to boil water or shelter in place or preventive measures with this system during emergencies. Additionally, select populations can be singled out for notification, so people would receive only applicable information. Public health used this notification system during the PanDorA exercise last November. The 9-1-1 system notified first responders on the first day of the exercise to report for influenza vaccinations. The system worked well.

Communicable Disease

As required by Chapter 333-014-0040, Columbia Health District "provides control of communicable disease which includes providing epidemiologic investigations which report, monitor, and control communicable disease and other health hazards; providing diagnostic and consultative communicable disease services; assuring early detection, education, and prevention activities which reduce the morbidity and mortality of reportable communicable disease; assuring the availability of immunizations for human and animal target populations; and collecting and analyzing of communicable disease and other health hazard data for program planning and management to assure the health of the public; "

During fiscal year 2005, the following reportable disease cases occurred:

	Columbia County	State of Oregon
AIDS	1	155
Campylobacteriosis	5	646
Chlamydiosis	89	9018
Cryptosporidiosis	0	69
E. coli 0157 infection	2	149
Giardiasis	6	419
Gonorrhea	14	1562
H. Influenza	0	54
Hepatitis A	0	50
Hepatitis B (acute)	2	101

Hepatitis B (chronic)	4	407
Hepatitis C (acute)	0	19
HIV	2	296
HUS	0	6
Legionellosis	0	15
Listeriosis	0	11
Lyme Disease	0	21
Malaria	0	13
Meningococcal Disease	1	56
Pertussis	1	623
Rabies, animal	0	8
Salmonellosis	2	409
Shigellosis	0	127
Early Syphilis	0	57
Tuberculosis	1	101
Vibrio parahaemolyticus	0	6
West Nile infection	0	8
Yersiniosis	0	17

All of these infections require varying levels of disease investigation, partner notification, patient education, and follow up. Gonorrhea cases in Columbia County have increased significantly over the last several years. No one cause for this increase has been identified. The hepatitises (A and B) have decreased dramatically with the advent of vaccine. Vaccines are the best preventive measure that medicine has and have clearly proven that. Although 42% of the reportable diseases in Oregon in 2005 were hepatitises, we are still catching up on this new reporting element for hepatitis C. More in-depth investigations may further increase our workload. Enteric illnesses contributed 40% of the reported diseases in 2005. The summer months are known for picnics, potlucks, and diarrhea caused by an enteric pathogen.

Investigations for Norovirus outbreaks in nursing homes and assisted living facilities have become the norm for the winter months. The investigations are performed by the Public Health Environmental Health Specialist. The facilities follow the advice of their epidemiologist to break the chain of communicability.

The public health officer participates in the investigations now given our public health preparedness grant. Public Health has also established an e-mail list of health professionals and is sending out CDC alerts regularly to update the community health care professionals on unusual occurrences or outbreaks.

Public Health has invested time in educating the public and Columbia County Board of Commissioners on current and upcoming issues (i.e. West Nile Virus and Severe Acute Respiratory Syndrome). A portion of Columbia County is covered by a vector control district. The director of the Vector Control District and the public health administrator have presented to the county commissioners about issues around spraying and lack of vector control services in some parts of the county. The DHS health services flyers have been sent out to community agencies throughout the county. Last year, West Nile virus was isolated from a dead bird in Clatskanie.

Health Statistics

The Columbia County registrar provides "health statistics which include birth and death reporting, recording, and registration; analysis of health indicators related to morbidity and mortality; and analysis of services provided with technical assistance from the state health division" according to Chapter 333-014-0050. Columbia County does not have a hospital and so only home births are recorded locally. The county registrar estimates three births were recorded during calendar year 2003. These babies are delivered by midwives or EMTs or lay people. Deaths are recorded in the county for those citizens who die in the county.

There were 514 babies born to Columbia County parents in 2005. Of those, 396 pregnant mothers received adequate prenatal care. Three hundred and sixty four of the pregnant mothers received care starting in their first trimester. There were missing data on about 90 mothers.

Of the deaths recorded for Columbia County residents in 2005, cancers and heart disease were the number one and two killers respectively. The cancer death rate was significantly higher than the state of Oregon rate with lung cancer being the most prevalent cancer.

Maternal and Child Health

The growing cost of healthcare in Oregon and the U.S. has been higher than the rest of the market for the last decade. The Office of Health Policy and Research produced a paper to the 74th legislative assembly titled "Trends in Oregon's Healthcare Market and the Oregon Health Plan" The short executive summary follows:

Chapter 1 focuses on *Oregon population trends and demographics* as well as *how much we spend on healthcare, healthcare affordability* and *the main drivers of healthcare costs*.

- One driver of changing healthcare needs and costs is a growing and shifting population. Oregon's population is changing rapidly, not only in total size but also in its age distribution, racial and ethnic makeup, and on economic factors. These changes have implications for health, health coverage, and healthcare utilization and costs in the years to come.
- Between 2006 and 2013, the fastest growing segments of the population in Oregon are those 65 to 64 years of age (26% projected growth) and those 70 to 74 years of age (45% projected growth). As these individuals age, their care will begin shifting from the employment-based private insurance system to the publicly financed Medicare program. As a result, Medicare spending will begin to rise.
- Approximately 72% of healthcare dollars spent in Oregon are spent on hospital care, physician services, and prescription drugs.
- Total spending for acute healthcare services in Oregon is estimated at \$16.8 billion in 2006 and is projected to be \$19.3 billion by 2008.
 - Budget studies based on work completed by the Economic Policy Institute show that Oregon families do not have the financial capacity to contribute significantly toward healthcare costs until they are earning at least 250% of the federal poverty level (\$51,625 for a family of four in 2007).
 - New medical technology is generally thought to be the most important long-term driver of healthcare cost, accounting for one-half to two thirds of the increase in healthcare spending in excess of general inflation.. Other cost drivers include the rise in medical treatment, waste and inefficiency in the healthcare system, the overall structure of health insurance and medical errors and medical liability.

Chapter 2 focuses on *the Oregon Health Plan* looking at trends and program changes from 2003 to 2006.

- Budget cuts in both entitlement and discretionary programs at the federal level due have resulted in significant challenges for Oregon. The Deficit Reduction Act of 2005, with new rules and requirements around citizenship, third party resources, targeted case management, provider taxes, transportation and rehabilitative services affects the Oregon Health Plan (OHP), the State Children's Health Insurance Program (SCHIP) and the Family Health Insurance Assistance Program (FHIAP).
- There were a total of 401,008 total OHP Medicaid and SCHIP enrollees in September 2006. Of total eligibles, 55% were children 18 years and under, 35% were adults 19-64 years of age, and 9% were adults 65 years and older. The OHP expansion population (OHP Standard) has decreased over 78,000 people or 78% since changes were made to the program in 2003. The OHP Standard program operates entirely without General Fund resources, using provider taxes, which are set to sunset in 2008, from the hospitals and managed care organizations.
- For every \$1 that Oregon invests in Medicaid, the federal government matches with approximately \$1.57. This injection of federal dollars has a positive impact on state business activity, available jobs, and aggregate state income. Medicaid payments to hospitals, nursing homes, and other health-related businesses pay for goods and services and support jobs in the state, triggering successive rounds of earning and purchases as they continue to circulate through the economy.

Chapter 3 focuses on *health insurance*, looking at trends in Medicare and private sources of coverage.

- Medicare provides health insurance coverage to over 531,000 Oregonians who are eligible because they are 65 or older (with ten years of Medicare-covered employment), have a disability as determined by the Social Security Administration, or have permanent kidney failure.
- Under the new Medicare prescription drug program that began on January 1, 2006, states must pay a percentage (90% in 2006, declining over nine years to 75%) of their fiscal year 2003 Medicaid spending for prescription drugs, for each dual eligible person enrolled in the Medicare prescription drug program. The revised payment by Oregon to CMS for was \$57.1 million dollars (\$6.1 million dollars less than the original scheduled payment) for 2006.
- As of January 2007, 62% of Oregon's Medicare population and 54% of the U.S. Medicare population was enrolled in Medicare Part D plans.
- The average annual increase in Oregon's health insurance premiums for most years between 1997 and 2004 far outpace the growth in per capita income or inflation. Due to an economic downturn and rising unemployment during the early 2000s, employers in Oregon offering insurance and employees eligible for insurance during 2004 was at the lowest point in nine years.

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- The percent of private sector establishments in Oregon that offer health insurance to their employees has dropped from 86% in 1996 to 80% in 2004. The percent of employees working in establishments that offer health insurance has declined from 62% to 53% from 1996 to 2004.
 - Health Savings Accounts have increased in popularity both nationally and in Oregon in recent years and premiums for these products are generally lower than the average single or family health insurance product. However, some economists remain skeptical that HSAs will significantly increase health insurance coverage in the U.S. —primarily because 71 percent of the uninsured in the United States are in a 10-percent-or-lower income tax bracket (55% are in the 0% tax bracket), and they have little to gain from the tax savings imparted by HSAs.

Chapter 4 focuses on *who's not covered* examining the impacts, trends and characteristics of the uninsured in Oregon.

- Oregon's recovering economy has not resulted in improvements in health insurance coverage —increasingly expensive health insurance premiums and declining employer-sponsored coverage are both likely contributors to Oregon's uninsured population, which remained statistically flat from 2004 at 17% uninsured to 15.6% uninsured in 2006.
- 43% of adults from age 18 to 64 who earn less than 100% of the federal poverty level (FPL), and 35% of adults who earn less than 200% FPL are uninsured in Oregon.
- OHP changes since 2003 have had impacts on access to healthcare for vulnerable populations, with most who lost coverage remaining uninsured and facing higher unmet needs for medical care, urgent care, mental healthcare and prescription medications. This is especially true for those with chronic illness. This could result in increased costs for these populations stemming from deferring or delaying care.

Chapter 5 focuses on *access* presenting information about the healthcare safety net in Oregon.

- A 2004 survey of children from low-income families in Oregon found that only 68% of those without healthcare coverage had a regular source of care. Children without a usual source of care were three times more likely to be taken to an emergency room or an urgent care clinic for regular care.
 - Access to care for the uninsured and underinsured is provided in large part by the healthcare safety net. The healthcare safety net is a community's response to meeting the needs of people who experience barriers that prevent them from having access to appropriate, timely, affordable and continuous health services.
 - Oregon's healthcare safety net includes Federally Qualified Health Centers (FQHC), Rural Health Centers, Tribal Health Centers, County Health Departments, Migrant Health Centers, School-Based Health Clinics (SBHC)
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Veteran's Administration Clinics, Volunteer and Free Clinics and hospital emergency departments, as well as some private healthcare providers.

- The provision of uncompensated care serves as an indicator of both the need for healthcare among people who are unable to pay, and the willingness and capacity of healthcare providers to absorb the impacts of making such care available in a community. Trends for uncompensated care often reflect increasing numbers of uninsured individuals and families in the community.

Chapter 6 focuses on *racial and ethnic health disparities* in Oregon by looking at what is known about disparities in healthcare, the changing make-up of Oregon's population, and the need for increased data collection efforts.

- In 1990, racial and ethnic minorities made up 9.2% of Oregon's population; in 2005, an estimated 17% of Oregon's population self-identifies as African-American, Native American, Asian/Pacific Islander and/or of Hispanic ethnicity.
- Disparities in access and coverage have serious negative health consequences: the infant death rate among African-Americans in Oregon is almost twice that of non-Hispanic whites.
- The physician workforce in Oregon, while largely representative of the underlying population, is under-represented for African-American physicians (.6%) and over-represented for Asian physicians (6.3%).
- Data is not routinely collected on access, health status or utilization for Oregon's racial and ethnic minorities. Standardized data collection is critically important to inform policy and to understand and eliminate racial and ethnic disparities in Oregon.

Chapter 7 focuses on *health status* by looking at the prevalence of chronic disease, high-risk conditions and modifiable risk behaviors.

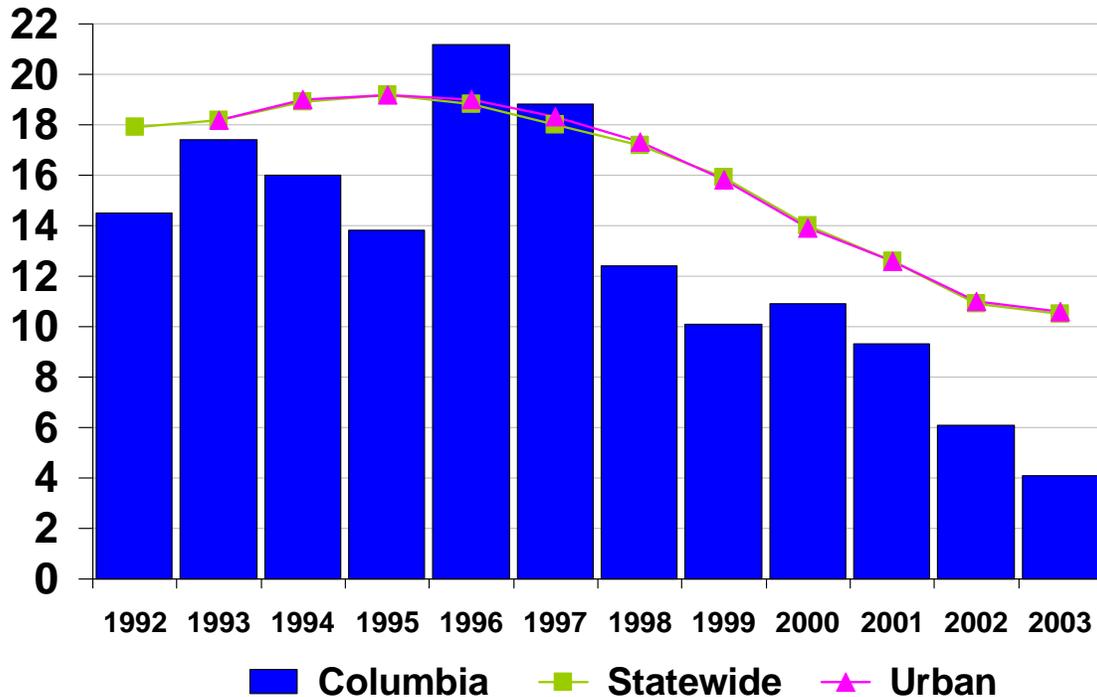
- Access to healthcare services impacts health status, but health status also influences demand for and the cost of healthcare. It is important, therefore, to examine healthcare both in the context of health status and as an important determinant of health outcomes.
- Chronic disease in Oregon represents areas of opportunity for the state where improved quality and access to primary healthcare can improve health status and reduce costs associated with these conditions. Although heart disease has decreased over the last fifteen years, diabetes has increased.
- High-risk conditions such as high blood pressure, high cholesterol, and obesity are strongly related to many chronic conditions. Screening for these conditions can help to detect chronic disease early in its development. Decreasing prevalence of these conditions is important in reducing the chronic disease burden in the population.

Chapter 8 focuses on *healthcare reform* by looking at current challenges and opportunities in Oregon as well as in other states.

- In 2006, Governor Kulongoski directed the Oregon Health Policy Commission (OHPC) to write a blueprint for building a sustainable system that provides access to affordable healthcare to every Oregonian, to set measurable goals for healthcare system change, and to recommend ways to finance the system.
- OHPC recommendations include:
 - o Universal health insurance for children
 - o Creation of a Health Insurance Exchange to bring together individuals, coverage options, employers, and public subsidies
 - o Offer low-income Oregonians publicly-financed coverage subsidies to ensure coverage is affordable
 - o Requirements that all Oregonians purchase health insurance coverage
 - o Encourage and organize public and private stakeholders to continuously improve quality, safety, and efficiency to reduce costs and improve health outcomes
 - o Support for community efforts to improve healthcare access and delivery
 - o Establish financing for reform that is sustainable and equitable with a broad-based employer contribution
 - o Design and implement comprehensive evaluation of system reform

Pregnancy rate per 1,000 females ages 10-17

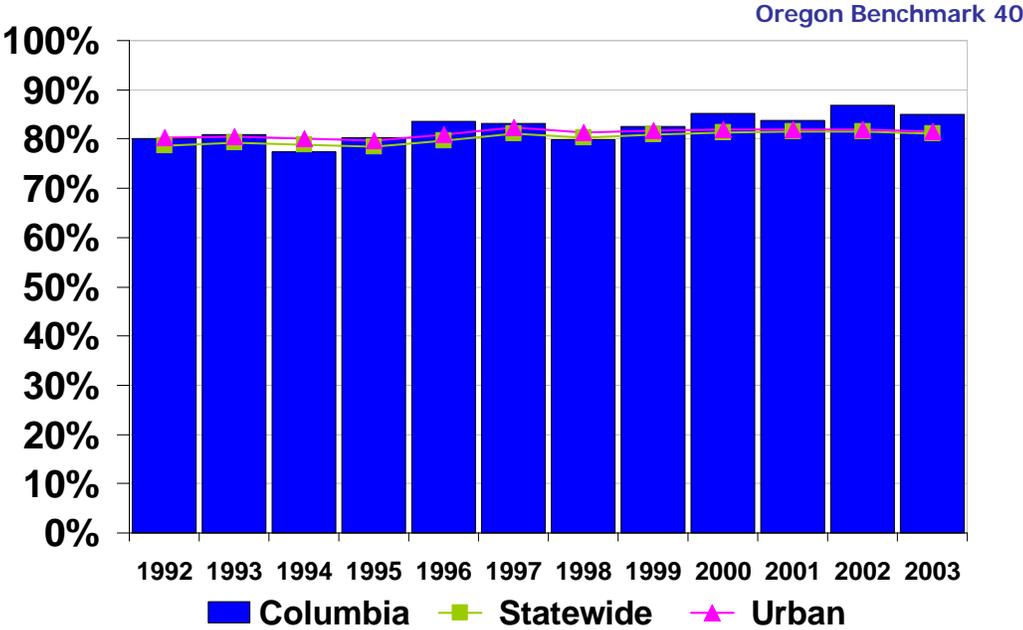
Oregon Benchmark 39



. Our teen pregnancy rate is less than the state rate at 10.9 girls age 10-17 yrs./1000. This statistic comes from the Status of Oregon's Children 2001 report. We attribute this to our STARS program and our family planning program. A recent report by the Guttmacher Institute states that abstinence only programs are not effective as stand alone programs in decreasing teen sexual activity. Availability of contraceptive services is effective in preventing teen pregnancy for sexually active teens.

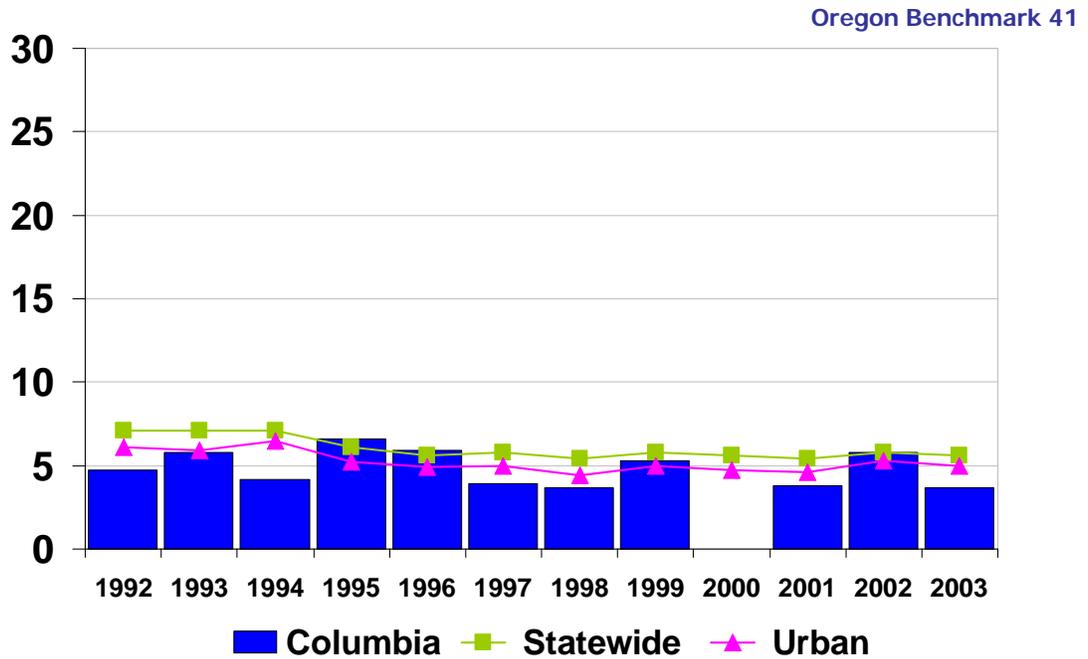
Agency staff provide home visits to new mothers, newborns, and infants with social or medical risk factors. Our nurses make referrals to medical and social services as needed. Staff time is extremely limited for these services and we hope in the future to be able to offer home visit nursing services to all parents of newborns in the county.

Percent of babies whose mothers received prenatal care beginning in the first trimester

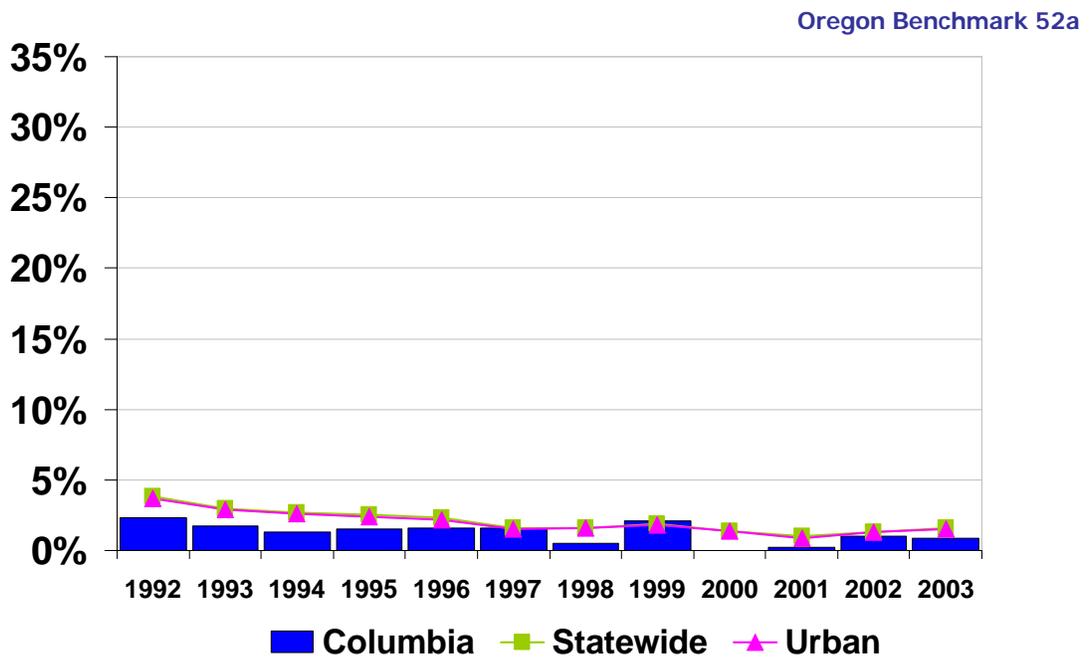


In 2005, there were 9 births to teens aged 10-17 years. Statistics from 2003-2005, list St. Helens with the highest number of teen births among the 15-17 yr. old range. There were 24 births during that three year timeframe in St. Helens.

Infant mortality rate per 1,000

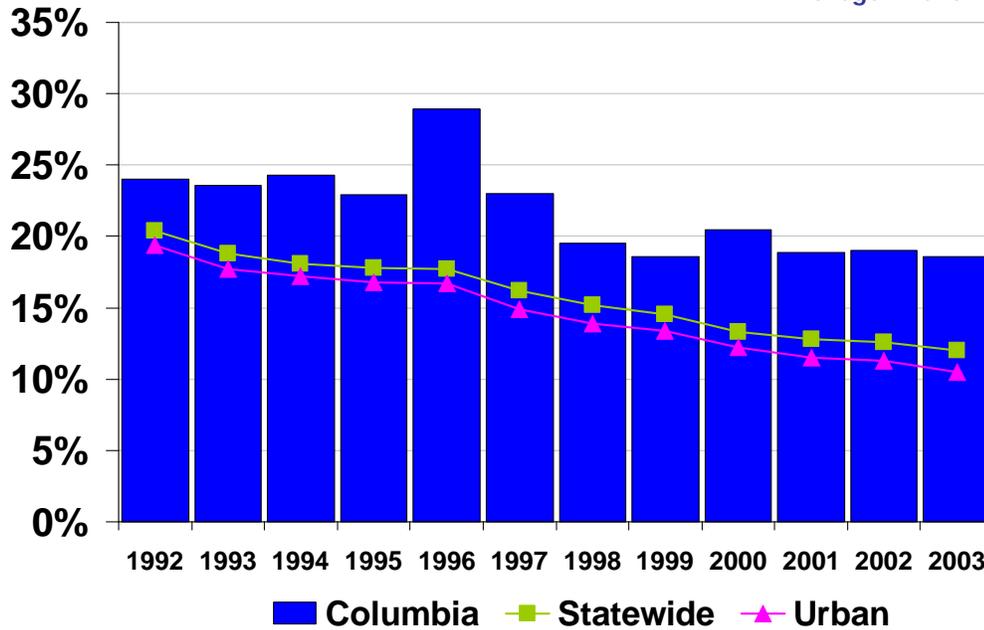


Percent of infants whose mothers used alcohol during pregnancy (self reported)



Percent of infants whose mothers used tobacco during pregnancy (self reported)

Oregon Benchmark 52b



Infant mortality during 2001 was higher than the year prior, but better than Oregon's average, when comparing a five year average rate. In 2004, there were two infant deaths. This is a difficult indicator to make any statements about because the numbers are too small for statistical comment. Columbia County has no obstetricians/gynecologists. Public Health offers a prenatal care program in conjunction with Oregon Health Sciences University. Legacy Health Systems offers prenatal care in St. Helens with two nurse midwives.

Columbia County has over 500 births a year, but no hospital where women can deliver their babies. They must travel to Washington state or to Portland to a hospital or deliver their babies at home. Women have access to three nurse midwives and one family practice physician countywide for prenatal care. Most women travel to Portland for prenatal care. High risk pregnant women are referred to Portland for their care. There are no local doctors who manage high risk pregnancies.

Low birth weight babies during 2005 born to Columbia County parents numbered 29 babies. This rate was lower than the previous year and lower than the state rate over a five year period of time. Entry into prenatal care in the first trimester was 87 percent, but six percent had inadequate care, defined as less than five visits or late entry into care. The risk factors for these women were not significantly different from the state's overall maternal risk factors. Ninety-nine of 524 pregnant women smoked during pregnancy. This indicator is higher than the state and higher than the urban area. Smoking has a tremendous impact on both the baby and the mother's health. That impact continues to negatively impact infants and children as they grow.

Top causes of Death and Prevention

The Centers for Disease Control (CDC) list the top ten actual causes of death in the following order:

1. Tobacco use or second-hand smoke
2. Poor diet
3. Alcohol consumption
4. Microbial agents
5. Toxic agents
6. Motor vehicle accidents
7. Firearms
8. Sexual behavior
9. Illicit drug use

This past year our county received limited tobacco dollars, although the state has both tobacco tax dollars and tobacco settlement dollars. Columbia County receives a small grant to educate and work with businesses and government around business policy. This program also works with schools and student groups. This is a limited three year focus.

Oregon has a clean indoor air act. The counties respond to complaints and provide the footwork for the state. The state health division also has very limited funds available to provide two counties with an asthma grant to help reduce the burden of respiratory problems in local communities. Columbia County is not a recipient of one of these grants.

The Dept. of Environmental Quality (DEQ) is the primary state agency to enforce outdoor air quality and has a very limited impact due to resources.

The second actual cause of death in the U.S. is poor diet. Counties provide diet education to several population groups. Through WIC, counties serve pregnant and breastfeeding women, infants and children through the age of four with nutritional risks. School-based health clinics and women's health clinics assess diet and educate if the client is interested. Columbia County has one school-based health clinic in St. Helens. It serves the K- 6 grade population. The community education programs available to the general public in our county are provided by the Columbia County Extension Service.

Public health in Columbia County has no program directed to alcohol consumption – the third leading cause of death in the U.S. There is information and referral to the local mental health agency which does provide alcohol and drug programs in the county. There are Alcoholics Anonymous (AA) programs available in every community in Columbia County.

The fourth largest actual cause of death in the U.S. is microbial agents. At this point in the top causes of death list, public health finally has invested dollars that will help protect the entire population. Columbia County public health has for 20 years offered both influenza and pneumonia vaccinations to the entire population.

Currently, some of the public health preparedness dollars are being used to purchase both of these vaccines. As part of our public health preparedness plan, we have developed a pandemic attachment to our overall emergency plan. This funding gives us the opportunity to plan for the most likely major public health problem that might occur. Planning is essential and so is practice. The agency is practicing, using these vaccines and administering them to infrastructure resources in our communities as well the general

population. When employees change, memories are short. Plans are not necessarily followed and chaos is created, so we continue to test our plans and exercise our employees on a yearly basis.

CDC's list of actual causes of death numbers five, six, and seven are not vested in any public health dollars in our county and so no services are provided.

The eighth cause of death from the list is sexual behavior. Here, public health is vested in providing family planning services that include sexually transmitted disease education well as screening. HPV vaccine is offered to all of our age appropriate clients. Public health also offers a sexually transmitted disease clinic for some types of sexually transmitted diseases.

Illicit drug use is the tenth actual cause of death in the CDC list. Our community mental health agency does the only drug treatment with extensive education in our county.

The unmet needs are many here. The dollars are finite and stretched thin.

Local Process and Progress

We continue to work with a health planning process. During a year-long process, we identified healthcare needs. With projected growth in the county, we need to address an increasing demand for services in an area where there is already a lack of supply. Columbia County is medically one of the most underserved counties in Oregon, and the only county its size without a hospital. We found a common barrier prevents much of our health planning for the county from being successful: the lack of a licensed inpatient hospital in the County. A hospital is central to a health service delivery system, and without one, isolated health services cannot develop into systematic health service delivery.

We lack physicians. The county needs about 19 primary care and 40 specialists. There is no hospital and no emergency room in the county and the closest ER is approximately 30 miles away. There is one urgent care clinic in the county and it does not provide services 24 hours a day. We have major unmet prevention and mental health needs, and all services in outlying rural areas are minimal.

Our population base is growing rapidly, yet we are not served by a transportation service. Additionally many residents have low income levels, and receive fewer services because of the lack of local health services and the challenges of transportation to outside services.

Children are particularly under served--we have a projected need for four pediatricians, yet only one currently practices in the county. In both Clatskanie and Vernonia, there is a higher death rate among young people than the rate for Oregon.

While some of following needs may be addressed individually, a hospital could provide a partial solution to many different problems and greatly enhance all efforts to increase health services

1. Need to obtain an emergency room that operates 24 hours/day and an inpatient hospital

2. Need to generate and distribute a recruitment packet for potential healthcare providers outlining advantages to practicing in Columbia County.

A local hospital is the cornerstone of a community health care system. The existence of a hospital is likely to support the presence of other medically related businesses and activities. Most commonly these are physician services, pharmacies, independent allied health professionals and others. These businesses or services are connected through a hospital and with each other.

A hospital can provide an enhanced sense of medical community among providers, i.e. medical staff and medical society. It makes it easier to attract and recruit physicians and specialists. It enables opportunities for improved coordination of existing local resources such as nursing homes, mental health, and physical therapy.

Further, it provides local infrastructure to a community.

FY 2008-09 Nutrition Education Plan Form

County/Agency: Columbia County
Person(s) Completing Form: Jana Mann & Micaela Swanson
Date: April 16, 2008
Phone Number: 503-397-4651
Email Address: jmann@chdpublichealth.com
mswanson@chdpublichealth.com

Goal 1: Oregon WIC staff will have the knowledge to provide quality nutrition education.

Objective: During the plan period, through informal discussions, staff in-services and/or targeted trainings, staff will be able to describe the general content of the new WIC food packages and begin to connect how these changes may influence current nutrition education messages.

Activity 1: Designated staff will participate in scheduled JAD sessions regarding the revision of current WIC food packages and the selection of new WIC food packages.

Staff: Jana Mann and Micaela Swanson

Resources: as supplied

Implementation and Timeline: Current and ongoing as they are already involved in the process.

Activity 2: By October 31, 2008, staff will review the Oregon WIC Key Nutrition Messages and identify which ones will require additional training.

Staff: all local agency WIC staff

Resources: Oregon WIC Key Nutrition Messages, American

Academy of Pediatrics, applicable internet resources,
And information provided at the state-wide meeting
Implementation and Timeline: will be completed by date above
through staff meetings during FY 2008-09.

Activity 3: By March 31, 2009, staff will review the proposed food packages/changes
And:

- Select three food packages/modifications
- Review current nutrition education messages most closely connected to those modifications, and
- Determine which messages will remain the same and which messages may need to be modified to clarify the reasoning for the food package change/reduction to facilitate effective client change.

Staff: all local agency WIC staff

Resources: information provided by the state

Implementation Plan and Timeline: will be completed by the date above through staff meetings during FY 2008-09.

Activity 4: Staff in-service dates and topics for FY 2008-09.

- July 2008 / Annual Plan Overview / Staff Development
- October 2008 / OWL / Staff Development
- January 2009 / Annual Plan Progress Check / Staff Development
- April 2009 / Proposed Food Packages / Staff Development

Training Supervisor: Jana Mann

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

Objective: During plan period, each agency will assess staff knowledge and skill level to identify areas of training needed to provide participant-centered services.

Activity 1: By September 30, 2008, staff will review the diet assessment steps from The Dietary Risk Module and identify which one(s) will require additional training.

Implementation Plan and Timeline: will be completed by the date above through staff meetings during FY 2008-09.

Activity 2: By November 30, 2008, staff will evaluate how they have modified their Approach to individual counseling after completing the Nutrition Risk and Dietary Risk Modules.

Implementation Plan and Timeline: modules will be completed by September 1, 2008 and the activity will be completed by the date above.

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

Objective: During the plan period, in order to help facilitate healthy behavior change for WIC staff and WIC clients, each local agency will select at least one objective and implement at least one strategy from the Statewide Physical Activity and Nutrition Plan 2007-12.

Activity 1: Healthy Behavior Change for WIC Staff

Setting: Worksite

Objective: Improve the number of worksites with policies and programs that promote and support physical activity and healthy eating for employees and their family members.

Strategy: Identify and designate individuals or decision-makers to continually support, approve and promote physical activity and healthy eating.

Implementation and Timeline: current and ongoing as we continue to participate in the agency fitness incentive program and strive for 100% participation with the support of our administrator and board of directors.

Activity 2: Healthy Behavior Change for WIC Clients

Setting: Home / Household

Objective: Increase the number of Oregon families and children who meet the recommendation for physical activity

Strategy: Parents should be role models for healthy physical activity and eating

Implementation and Timeline: current and ongoing as we offer a variety of classes and educational materials about healthy food choices and physical activity

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

Objective: During plan period, in order to help improve breastfeeding outcomes for WIC participants, each local agency will select at least one setting, objective, and implement at least one strategy from the Statewide Physical Activity and Nutrition Plan 2007-12.

Activity 1: Improved Breastfeeding Outcomes

Setting: Home / Household

Objective: Maintain the current level of breastfeeding initiation and increase by 2% a year the number of mothers who breastfeed exclusively for the first 6 months of a child's life.

Strategy: Local agency strategies include more specialized breastfeeding classes both before and after delivery, bilingual breastfeeding

support, and breastfeeding education for the whole family.
Implementation and Timeline: The new classes have entered the rotation beginning July 2008. Bilingual support is current and ongoing.

FY 2008-09 Family Planning Program Action Plan

- A. Assure Continued High Quality Clinical Family Planning and Related Preventive Health Services to Improve Overall Individual and Community Health.**
- B. Reduce Risk of Unintended Pregnancy in Local Community.**

UPDATE ON CURRENT CONDITION OR PROBLEM:

Columbia County statistics showed an estimated 1,979 *Women In Need (WIN)* 2006, ages 13-44 according to the *Title X Family Planning Agency Data* information provided by DHS.

Our family planning clinic served 753 unduplicated female clients, 10-44 years of age for FY 2007, or 38.0% of *Women In Need (WIN)*, well above the state average of 32.7%. From the *Title X Family Planning Agency Data* we also see that there were 443 *Women in need (WIN)* Teens 13-19 years of age for FY 2006. Our family planning clinic served 301 unduplicated female teen clients 10-19 years of age for the FY 2007, or 41.3% teen clients as a % of total clients, well above the State average of 27.4%.

Pregnancy Rates of Teens by County of Residence, Oregon 2005 shows teen pregnancy rate in ages 10-17 as 4.0 per 1000 women in Columbia County. This is significantly lower than the State average of 9.5%. (We are the 2nd lowest in the State!). **Oregon Vital Statistics Annual Report 2005, DHS, Table 4-5*. This is a reduction from the Oregon 2004 data, which showed the teen pregnancy rate ages 10-17 as 6.6 per 1000 women.

Our Teen pregnancy rate for 10-17 year old women CY'04 = 6.6 – 5 year average = 7.4 (State rate CY'04=9.5). Our Rolling Rate from 10/04-0/05 = 4.0, well below the State Rolling Rate = 9.5. **Data supplied by Cheryl Connell at 11/06 Data Review*. Our moving total, rolling rate and 2007 YTD Preliminary Rolling Rate (Jan. '07 to Dec. '07) = 3.7, the 3rd lowest in the State! And well below the State Rolling Rate=8.8 for 2007. **Teen Pregnancy Chart, DHS*.

Many teens in Columbia County are unemployed, or working at minimum wage jobs. The U.S. Census 2000 Quick facts shows the percent of High School graduates in Columbia County aged 25+ as 85.6%, and those with a Bachelor's degree or higher as 14.0%. The Median household income in Columbia County for 2004 = \$49,227. **U.S. Census Bureau State & County Quick Facts*. Postponing parenthood will allow these young adults more time to improve their wages, continued education and employment possibilities. The Family Planning Program – FY

Data Review provided from DHS reports that our agency averted 79 teen pregnancies (under 20 years of age) and 117 Adult pregnancies (20+ years old).

Page 1

Columbia County is a rural community with an estimated population of 49,163 people in 2006. **U.S. Census Bureau State & County Quick Facts.*

There is currently limited public transportation system, and our clients must travel by their own transportation, walk, use bicycles, or pay for a Taxi/Metro West bus service.

Our clinic hours of operation remain limited due to funding and space availability. As funds become available we hope to increase staffing, and clinic hours of operation.

We continue to take great pride in providing quality confidential reproductive health care education and information to men, women and teens in need seeking services.

Included in our direct services we provide an abstinence program called STARS (Students Today Aren't Ready for Sex) to St. Helens and Scappoose school districts in Columbia County, through Teen leaders trained in the STARS curriculum. There are approximately 280 active teens involved in the STARS program in St. Helens School District and 16 teen leaders assisting to provide the curriculum, from St. Helens High School. Scappoose School District has approximately 180 active teens involved in the STARS program, with 17 teen leaders providing the curriculum to the preteens.

This is the first time that Scappoose School District has been involved in the STARS program! Vernonia School District was unable to participate this year due to a recent natural disaster (flooding), and they are using a modified school system.

STARS has a strong advisory board member at the State level who has been able to help coordinate our efforts to get all Columbia County districts involved in the curriculum.

**FAMILY PLANNING PROGRAM ANNUAL PLAN FOR
COUNTY PUBLIC HEALTH DEPARTMENT
FY'08**

**Agency: Columbia Health District Public Health
Contact: Diana Shrewsbury RN, BS**

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

Problem Statement	Objective(s)	Planned Activities	Evaluation
Changes in FPEP Enrollment has led to increased staff time without additional reimbursement, threatening the ability of the agency to maintain current level of service.	1) Increase revenue from donations by 1% for the period ending June 30, 2008	1) Develop a donation policy and procedure consistent with Title X guidelines. 2) Train staff in positions to make the donation requests. 3) Implement donation request policy. 4) Evaluate policy for consistency, fairness and effectiveness.	1) Quarterly and fiscal year end revenue reports. 2) Customer feedback. 3) Staff feedback.

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

Problem Statement	Objective(s)	Planned Activities	Evaluation
Mirena IUD's available – none inserted to date	1) CNM will offer Mirena IUD as BC Method 2) Insertion of Mirena IUD device	1) Identify clients that are suitable for the Mirena IUD 2) Utilize ARCH foundation for clients who are not FPEP and meet eligibility criteria	1) # of Mirena IUD's inserted

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

FY'09

July 1, 2008 to June 30, 2009

**Agency: Columbia Health District Public Health
Shrewsbury RN, BSPH**

Contact: Diana

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

Problem Statement	Objective(s)	Planned Activities	Evaluation
Only 2.3% of total clients are male.	Increase the percentage of male clients served by 1%.	<ol style="list-style-type: none"> 1) Attend community events, i.e. fairs and festivals, and provide FPEP flyers and information. 2) Continue community outreach. 3) Attend school based Health Center county wide planning meeting March 6th. 4) Attend Vernonia and Rainier School Health Committee Council Meeting. 5) Make clinic Male friendly environment 	Increase number of males seen by 1% by December 2008.

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

Problem Statement	Objective(s)	Planned Activities	Evaluation
<p>There were 443 Women in need teens 13-19 years of age for FY 2006. Our clinic served 301 unduplicated female teens 10-19 for FY 2007, or 41.3% (State average is 27.4%).</p>	<p>Increase the percentage of teen clients seen by 1%.</p>	<ul style="list-style-type: none"> 6) Attend community events, i.e. fairs and festivals, and provide FPEP flyers and information. 7) Continue community outreach. 8) Attend school based Health Center county wide planning meeting March 6th. 9) Attend Vernonia and Rainier School Health Committee Council Meeting. 	<p>Increase number of teens seen by 1% in the December 2008.</p>

Progress on Goals / Activities for FY 08

(Currently in Progress)

Goal / Objective	Progress on Activities
Changes in FPEP enrollment have led to increased staff time without additional reimbursement, threatening the ability of the agency to maintain current level of service	<ol style="list-style-type: none"> 1) Plan to request an example of a Donation Policy consistent with Title X guidelines from DHS in order to develop our own within the next 2 months. 2) 4 staff members have quit since 7/1/08, we have hired 5 new staff members and are in the process of training. 3) Once policy is developed we will evaluate it for consistency, fairness and effectiveness 4) No client donations have been made to clinic by clients to date.
Mirena IUD's available- none inserted to date	<ol style="list-style-type: none"> 1) Mirena IUD's are now being offered as a BC method to all suitable clients. 2) 0% of our population has qualified for the ARCH foundation based on their eligibility requirements. 3) A total of 27 clients have been identified as suitable and a total of 12 clients have returned for Mirena insertion (as of 1/23/08).

Maternal and Child Health Action Plan 08-09

CURRENT CONDITION OR PROBLEM:

Pregnancy totals for all ages in Columbia County, Oregon, 2006 = 510.

**Oregon Vital Statistics County Data 2006, DHS, Table 4.*

Of this total, 3.6% received inadequate prenatal care (less than 5 prenatal visits or care began in 3rd trimester). This is significantly lower than the State average of 6.2%. Columbia County ranked in the top 3 for clients who received adequate prenatal care. **Oregon Vital Statistics County Data 2006, DHS, Table 8.*

In 2006, 83.1% of the 510 pregnant women in Columbia County, received prenatal care in the 1st trimester, this is significantly higher than the State average of 79.2%. **Oregon Vital Statistics County Data 2006, Table 8.*

Of the 510 total live births, 26 infants were born with low birth weight, or a low birth rate of 51.0 per 1000 births, compared to the State average low birth rate of 61.0 per 1000 births. **Oregon Vital Statistics County Data 2006, DHS, Table 14.*

Based on the Perinatal Data provided by DHS, Columbia County Public Health Authority provided prenatal care to 110 unduplicated women from July 2005 to June 2006:

- 97 were unplanned
- 78 had Nutritional Risk Factors
- 41 had Tobacco Use
- 12 had Substance Abuse Issues
- 2 noted Domestic Violence
- 21 had no High School Degree
- 3 were 17 years of age or under
- 5 were homeless
- 80 were unmarried

(Perinatal Health Program Client Service Annual Report for – FY 2007; July 2006 to June 2007 is unavailable at the date of this compilation of current data, d/t complications interfacing the old perinatal data system and ORCHIDS implementation).

Current Condition or Problem:

Our most difficult problem for pregnant women in Columbia County, is smoking during their pregnancy, or relapsing during the postpartum period. Many of our pregnant women know they should quit, but are lacking the support and tools to help them achieve their smoking cessation goals. A majority of our prenatal clients are motivated to quit smoking during their pregnancy and are in need of the support for smoking cessation and information to help them quit and not relapse. Pregnancy is the best time for a woman to quit smoking. Smoking during pregnancy can cause serious health consequences to the mother and her baby. Statistics show poor birth outcomes such as; low infant birth weights, increased risk of miscarriage, an increased risk of still-births, pre-term

births, slower fetal growth, allergies, asthma, ear infections, respiratory illnesses and Sudden Infant Death Syndrome (SIDS).

*Maternal Risk Factors by County of Residence, Oregon 2006 shows Tobacco use in pregnant women in Columbia County was 22.2%, our County ranks 8th highest in the State of Oregon, and above the State average of 12.3%. *Oregon Vital Statistics County Data 2006, DHS, Table 11.*

Goal:

- *Promote smoking cessation during Pregnancy and in the postp period.*
- *Provide the Great Start Quit Line and Oregon Tobacco Quit Line phone number and encourage referrals with follow-up at each Prenatal and Postpartum visit.*
- *Decrease SIDS deaths in Columbia County.*

Activity:

- *Document the use of the 5A interventions on the Fair form in each prenatal client record at each visit.*
- *Collaborate with WIC staff, Babies First Nurse and Community Health Nurse each month to discuss smoking prenatal clients and progress or regression in each shared client.*
- *Promote smoking case management tools adapted to each client's individual needs to improve success with smoking cessation during pregnancy and in the Post Partum Period.*
- *Continue to praise clients on progress made and refer to either Great Start Quit Line or Oregon Tobacco Quit Line, or both.*

Evaluation:

- *Nursing Professionals will continue to track the smoking cessation attempts, the interventions, success and regressions at each prenatal visit.*
- *WIC, Family Planning, MCM, and the home visiting nurse programs will track the smoking status of the prenatal clients during pregnancy and postpartum period.*
- *The Oregon Vital Statistics county Data book will not show an increase in number of pregnant women who use tobacco, and will hopefully see a reduction in this number in the next few years.*

**FY 2008-09 Environmental Health Plan
Columbia Health District Public Health
Staff: Mark Edington, sanitarian**

In accordance with OAR 333-014-0050(2)e The Columbia Health District will provide a licensed Environmental Health Specialist to do the following inspections: Inspection, licensure, consultation and complaint investigation of food service, tourist facilities, institutions, public swimming pools and spas, and regulation of water supplies.

Solid waste and sewage disposal systems services are contracted by Columbia County Land Development Services. In the last triennial review, CHD Public Health lacked an Environmental Health Ordinance to deal with revocation or suspension issues and other issues. CHD Public Health hired a law firm to put together an ordinance in accordance with ORS 624. A copy of the ordinance was adopted by the board in October 2007.

The triennial review revealed that inspections made did not always detail the reference to the OAR that was applicable. Also, followup inspections were not always made on critical items that were not corrected at the time of inspection. A concerted effort has been made to see that followup inspections are made as required since the triennial review in 2006. Now, all inspections make reference to an applicable OAR as required.

The Triennial review from 2006 required that a Water Emergency Response plan be adopted. That document is a work in progress. All drinking water issues will be dealt with according to the contract.

**2008-09 Babies First/CaCoon Annual Plan
Columbia Health District Public Health
Staff: Danielle Nelson RN, BSN
Public Health Nurse**

Goal: The goal of the Babies First Program is to improve the physical, developmental, and emotional health of high risk infants in Columbia County. The Babies First Nurse will also assist families to identify and access the appropriate community resources that meet their child's specific needs.

Activities:

- High risk infants referred to the Babies First program will be screened using standardized tools to detect developmental delay and/or other health/medical related problems. All children found to have abnormal screening will be referred for intervention.
- All families will be assessed for targeted case management needs and those who qualify will receive targeted case management services.

Evaluation: Demographic and outcome data will be collected on each patient visit and recorded in ORCHIDS.

FY 2008-09 Immunization Annual Plan
Staff: Ines deSouza, Public Health Nurse
Kaley Martin, Immunization Clerk

This year we continue to perform our core Public Health function and work toward continuous quality improvement.

We are once again offering immunizations to the out lying areas of our county in conjunction with the traveling WIC clinics.

We are now offering Tdap to all 11 and 12 year olds and those people needing tetanus boosters. Our staff is also educating clients on the importance of this vaccine in preventing pertussis outbreaks in Oregon. We have also started offering meningococcal vaccine in our immunization clinic.

We plan to continue to work through the matrix of our core Public Health framework during the next fiscal year.

Our goal is to increase immunization travel clinics to at least six times this fiscal year.

FY 2008-09 Tobacco Prevention and Education Plan
Staff: Ederlinda Ortiz-Clawson, program manager
Ashley Swanson, Outreach Coordinator

SMART OBJECTIVE #1: TOBACCO-FREE SCHOOLS

Currently, the only school in Columbia Co. that does not have a comprehensive tobacco-free policy on file is Scappoose School District.

- By June 30, 2008, Scappoose School District will have passed and adopted comprehensive tobacco-free school policies.
- By June 30, 2008, 5 of 5 school districts in Columbia Co. will have comprehensive tobacco-free policies in place.

1. GOAL AREAS FOR THIS OBJECTIVE

- Eliminating/reducing exposure to secondhand smoke-primary
- Countering pro-tobacco influences-secondary
- Reducing youth access to tobacco-primary
- Promoting quitting-secondary

2. PLAN OF ACTION

Coordination/Collaboration:

CHD TPEP staff shall work closely with ALA and the Scappoose School district to review current tobacco related policies in place. By Jan. 31, 2008, CHD TPEP staff will coordinate an initial telephone conference with the Scappoose Superintendent and ALA point staff person and assess the current status of tobacco-free school policies.

Assessment and Research:

Prior to Jan. 31, 2008, CHD will review Scappoose School District's current tobacco-related school policies.

Community Education, Outreach, and Media:

By Jan. 31, 2008, provide Scappoose School District Superintendent, Paul Peterson, with articles supporting strong "gold standard" tobacco-free school policies.

Policy Development and Implementation:

By Feb 28, 2008, Scappoose School District Superintendent, Paul Peterson will have model "gold standard" tobacco-free school policies approved by the school board and in place. CHD will work with Mr. Paul Peterson to promote The Oregon Quitline to staff and students through appropriate outlets (such as website, newsletters, etc.)

3. CRITICAL QUESTIONS

A. What sectors of the community will this objective reach?

Students, their families, school district staff, community members, and visitors

B. Are there segments of the population who will not receive benefit from this objective?

No

C. What types of technical and/or data assistance do you anticipate needing from:

1. **TPEP staff?** Nothing for this objective

2. **Statewide capacity building programs for eliminating disparities?**
None

1. SMART OBJECTIVE #2: TOBACCO-FREE HOSPITALS

Currently, there isn't a hospital in Columbia Co. However, there are plans to build one and a Community Hospital Foundation has been formed to guide the process. The timeline is uncertain at this time. CHD TPEP staff shall remain in close contact with the Hospital Foundation to ensure that the future hospital drafts and passes tobacco-free campus policies. Once timelines are better outlined, we may be better able to draft a clearer objective for tobacco-free hospitals.

2. GOAL AREAS FOR THIS OBJECTIVE

- Eliminating/reducing exposure to secondhand smoke-primary
- Promoting quitting-secondary

3. PLAN OF ACTION

Coordination/Collaboration:

CHD TPEP staff shall remain in close contact with the Community Hospital Foundation and assess the timing of tobacco-related objectives. We will stay in contact with OHD TPEP to organize strategies as the issue becomes more relevant.

Assessment and Research:

Community Education, Outreach, and Media:

Policy Development and Implementation:

4. CRITICAL QUESTIONS

What sectors of the community will this objective reach?

Are there segments of the population who will not receive benefit from this objective?

What types of technical and/or data assistance do you anticipate needing from:

TPEP staff? Nothing for this objective

Statewide capacity building programs for eliminating disparities?

None

Columbia Health District Public Health – TPEP Plan Form

1. SMART OBJECTIVE #3: TOBACCO –FREE COMMUNITY COLLEGES

Columbia County does not have a community college. There is no feasible target for this objective.

Columbia Health District Public Health – TPEP Plan Form

1. SMART OBJECTIVE #4 – SMOKE-FREE MULTI-UNIT HOUSING

By December 31, 2008, 6 of 24 (25%) multi-unit housing facilities in Columbia County will be completely smoke-free.

2. GOAL AREAS FOR THIS OBJECTIVE

- Eliminating/reducing exposure to secondhand smoke-primary
- Countering pro-tobacco influences-secondary
- Promoting quitting-secondary

3. PLAN OF ACTION

Coordination/Collaboration:

May 2008

CHD TPEP staff will work with the Community Action Team (CAT) and powermap and identify key community stakeholders for the development of a multi-unit housing tobacco free taskforce.

June – July 2008

Meet with each member of the coalition to discuss the development of tobacco free multi-unit housing facility policies.

August 2008

Conduct first taskforce mtg. Identify strategy and set timeline.

August 2008

Begin promotion of Oregon Quitline in collaboration with rental housing community

Assessment and Research:

April - May 2008

Conduct research; build knowledge base among CHD TPEP staff

Community Education, Outreach, and Media:

June 1 – Sept. 30, 2008

Order ed materials from the Clearinghouse, draft introduction letter to landlords, rental associations, and other housing programs, mailer with materials to aforementioned members, follow-up with phone contact and scheduling face-to-face meetings. Coordinate with Metro Group media strategy (MAC Plan).

Policy Development and Implementation:

Sept. 2008

Model draft policy after Multnomah Co.'s smokefree multi-unit housing policies.
CHD to work with TPEP Policy Manager.

4. CRITICAL QUESTIONS

A. What sectors of the community will this objective reach?

Rental housing tenants and their families, rental housing association,
businesses, workers

B. Are there segments of the population who will not receive benefit from this objective?

Yes, home owners

C. What types of technical and/or data assistance do you anticipate needing from:

- 1. TPEP staff?** Policy drafting and implementation tools
- 2. Statewide capacity building programs for eliminating disparities?**

No

1. **SMART OBJECTIVE #5 – Local Agreements for Enforcement of the Smokefree Workplace Law**

IGA already in place.

1. SMART OBJECTIVE #6 – IMPLEMENT SMOKEFREE WORKPLACE LAW

By April 2008, CHD Public Health will have Board approved policy and procedure in place to respond to complaints of violation of the Smokefree Workplace Law.

2. GOAL AREAS FOR THIS OBJECTIVE

- Eliminating/reducing exposure to secondhand smoke-primary
- Countering pro-tobacco influences-secondary
- Promoting quitting-secondary

3. PLAN OF ACTION

Coordination/Collaboration:

Feb. 2008

CHD TPEP will coordinate with our Sanitarian and see if there are opportunities to coordinate efforts

Assessment and Research:

Feb. 2008

Review other TPEP grantees' procedures for handling complaints.

Community Education, Outreach, and Media:

May 2008

Press release in local media outlining Smokefree Workplace Law and procedures for filing a complaint or advising of possible violations
Coordinate with Metro Group media strategy (MAC Plan).

Policy Development and Implementation:

March 2008

Model draft policy after other TPEP grantees' procedures
Present policy to CHD Board for approval.
CHD to work with TPEP Policy Manager.

4. CRITICAL QUESTIONS

A. What sectors of the community will this objective reach?

Community members, businesses, CHD Staff

B. Are there segments of the population who will not receive benefit from this objective? no

C. What types of technical and/or data assistance do you anticipate needing from:

1. TPEP staff? no

2. Statewide capacity building programs for eliminating disparities?

No

1. SMART OBJECTIVE #7 – BUILD CAPACITY FOR TOBACCO RELATED CHRONIC DISEASE

By January 31, 2009, compile a profile of the prevalence of all tobacco related chronic disease in Columbia County.

2. GOAL AREAS FOR THIS OBJECTIVE

- Eliminating/reducing exposure to secondhand smoke-primary
- Countering pro-tobacco influences-secondary
- Promoting quitting-secondary

3. PLAN OF ACTION

Coordination/Collaboration:

Assessment and Research:

Oct. 2008

Coordinate with TPEP research analysts and collect data sets specific to Columbia County.

Oct. 2008

Attend APHA conference in San Diego, CA for staff development and build capacity for tobacco-related chronic disease.

Nov. 2008

Review and gain an understanding of the data and build a framework for identifying areas of focus.

Community Education, Outreach, and Media:

Policy Development and Implementation:

4. CRITICAL QUESTIONS

A. What sectors of the community will this objective reach?

All Columbia Co. residents

B. Are there segments of the population who will not receive benefit from this objective?

C. What types of technical and/or data assistance do you anticipate needing from:

1. **TPEP staff?** Data collection and understanding data sets
2. **Statewide capacity building programs for eliminating disparities?**
Maybe?

1. SMART OBJECTIVE #8 – SMOKEFREE WORKPLACES

By December 2008, 50% of (not sure of total number of workplaces) exempt from the Oregon smokefree law will be completely smokefree.

2. GOAL AREAS FOR THIS OBJECTIVE

- Eliminating/reducing exposure to secondhand smoke-primary
- Countering pro-tobacco influences-secondary
- Promoting quitting-secondary

3. PLAN OF ACTION

Coordination/Collaboration:

Feb. 2008

Coordinate with CHD Environmental staff, local Oregon Liquor Control Commission, local Lottery Commission, and other relevant partners and brief them about the campaign to encourage exempt workplaces to go smokefree before 01/01/2009.

Feb. 2008

Develop a smokefree workplace coalition

March 2008

Conduct first coalition mtg. Identify strategy and set timeline.

March 2008

Begin promotion of Oregon Quitline to exempt workplaces

Assessment and Research:

March 2008

Collect relevant data sets. Conduct research; build knowledge base among CHD TPEP staff

Community Education, Outreach, and Media:

April, June, Aug., Oct., Dec. 2008

Implement “Why Wait” campaign. Coordinate with Metro Group media strategy (MAC Plan).

Policy Development and Implementation:

April, June, Aug., Oct., Dec. 2008

Continue to provide on-going support and Oregon Quitline materials to exempt workplaces for implementation.

4. CRITICAL QUESTIONS

A. What sectors of the community will this objective reach?

Currently exempt workplaces and their patrons and employees

B. Are there segments of the population who will not receive benefit from this objective?

Yes, folks who do not frequent exempt workplaces.

C. What types of technical and/or data assistance do you anticipate needing from:

- 1. TPEP staff? implementation tools**
- 2. Statewide capacity building programs for eliminating disparities?**

No

1. SMART OBJECTIVE #10 – SMOKEFREE COMMUNITY EVENTS

By June 30, 2009, a minimum of 5 community events in Columbia Co. will be completely smokefree. Targeted events are in each of the major cities in Columbia County. The events are:

- a. Scappoose – Sauerkraut Festival
- b. St. Helens – Riverfest Days and/or Oktoberfest
- c. Vernonia – Jamboree
- d. Rainier – Rainier Days
- e. Clatskanie – Blues Festival

2. GOAL AREAS FOR THIS OBJECTIVE

- Eliminating/reducing exposure to secondhand smoke-primary
- Promoting quitting-secondary

3. PLAN OF ACTION

Coordination/Collaboration:

Feb. – Apr. 2008

Identify all the events planning committees and establish contact. Delegate staff to planning committees.

Assessment and Research:

March – May 2008

Collect relevant data sets. Conduct research; build knowledge base among CHD TPEP staff

Community Education, Outreach, and Media:

June 2008

MAC Plan with MetroGroup

Policy Development and Implementation:

June-July 2008

Draft policy language for smokefree community events. Share and disseminate with respective planning committees.

August – Sept. 2008

Draft sample signage language for policy adherence once policy is established.

4. CRITICAL QUESTIONS

A. What sectors of the community will this objective reach?

Businesses, civic groups, community members, families, etc.

B. Are there segments of the population who will not receive benefit from this objective?

Yes, folks who do not attend these functions

C. What types of technical and/or data assistance do you anticipate needing from:

- 1. TPEP staff?** implementation tools, policy language
- 2. Statewide capacity building programs for eliminating disparities?**

No

1. SMART OBJECTIVE #18 – TOBACCO RETAILER COMPLIANCE WITH THE LAW REGARDING NO-TOBACCO SALES TO MINORS

By June 30, 2009, all (need to get number) retailers in Columbia Co. will be compliant with the law regarding no-tobacco sales to minors.

2. GOAL AREAS FOR THIS OBJECTIVE

- Countering pro-tobacco influences-primary

3. PLAN OF ACTION

Coordination/Collaboration:

Feb. 2008

Coordinate with school districts and OSSOM students to form a coalition to focus on tobacco retailers

March 2008

Conduct first coalition mtg. Identify strategy and set timeline.

March 2008

Begin promotion of Oregon Quitline to tobacco retailers

Assessment and Research:

March 2008

Gather list of tobacco retailers. Create and maintain database of retailers and compliance.

Community Education, Outreach, and Media:

April, June, Aug., Oct., Dec. 2008

Implement reward and reminder campaign. Coordinate with Metro Group media strategy (MAC Plan).

Policy Development and Implementation:

April, June, Aug., Oct., Dec. 2008

Continue to provide on-going support and Oregon Quitline materials to tobacco retailers

4. CRITICAL QUESTIONS

A. What sectors of the community will this objective reach?

Students, tobacco retailers

B. Are there segments of the population who will not receive benefit from this objective?

C. What types of technical and/or data assistance do you anticipate needing from:

- 1. TPEP staff? implementation tools**
- 2. Statewide capacity building programs for eliminating disparities?**
No

1. Application Cover (attachment #1)
2. Commitment Forms (attachment #2)
3. Completed Budget (March 1 thru June 30, 08) (July 1 – Dec. 30, 2008) (attachment #3)

4. Letters of Support (attachment #4)

An email was distributed to a list of approximately 20 organizations throughout Columbia County. The email detailed the objectives of our proposal; compelling data highlighting the impact tobacco use has on our communities, and a request to demonstrate support through letters. We were overwhelmed with the response from our community partners. Here are a few we have submitted to demonstrate the high level of support for on-going and developing tobacco prevention and control efforts.

- a. Columbia County Commissioners
- b. Sacagawea Health Center
- c. Columbia Community Mental Health
- d. Commission on Children and Families
- e. Columbia River Fire and Rescue
- f. Boise Cascade
- g. Scappoose School District
- h. Rainier School District

5. Statement of Need (2 page maximum)

Columbia County is in a current state of recovery due to recent federally declared emergencies brought on by Storm 2007.

Despite this strained climate, communities are instinctively looking to rebuild and desire for themselves and their neighbors a broader sense of health and wellness. And, communities *are* beginning to rebuild. Whether directly impacted or not, dialogue can be chronicled in each of the cities of Columbia County expressing a vision and hope for healthier, more vibrant and thriving community. The timing for this grant coincides with the recovery timelines with many communities, especially Vernonia as they look to relocating and building all new facilities for the school district. As you may know, the Vernonia schools including the District office were all affected with flood waters. It will be critical to mitigate mold. Surveillance mechanisms are in place to track upper respiratory illnesses and diseases such as asthma. The areas of Columbia County that experienced flooding are Vernonia, St. Helens and Clatskanie.

Along with this fundamental need to heal, compelling chronic disease and tobacco data quantify our need for program expansion dollars.

Columbia Health District-Public Health Authority (CHDPHA) has been successful through its current TPEP grant and other public health endeavors, in garnering trust and respect of community leaders/partners in St. Helens, Scappoose, Vernonia, Rainier and Clatskanie. CHDPHA staff are engaged in collaborative discussions with groups throughout Columbia County on many public health issues and topics to include school based health centers, tobacco prevention, and preparedness. The school districts are the hub of each of our communities. It has been through our collaborations with schools that we have been able to engage many community wide partnerships. CHDPHA has assisted the school districts throughout the County in securing grant funds to enhance and support public health prevention and promotion efforts for their faculty, students and families such as the Healthy Kids Learn Better program. Thoughtful consideration and time has and as is being spent in each of these (5) main cities to develop and strengthen relationships with CHDPHA.

The need for the expansion of CHDPHA's current tobacco prevention efforts is tremendous. These grant funds would be used to support the essential components of grassroots community building that lends itself to positive long term public health outcomes. We currently participate with three school health advisory councils through "Healthy Kids Learn Better" program funded by DHS and ODE.

It is our assumption that community partners will want to engage in the public health tobacco prevention dialogue when an understanding of the negative impact tobacco use has on chronic diseases and the overall health of the community is achieved. This funding opportunity provides a wider platform from which CHDPHA may engage a broader cross section of community members. It also assists by leveraging credibility to current tobacco prevention efforts.

6. Demographics (2 page maximum)

See attachment #5 for copy of population demographics

Economic Indicators:

Columbia County has a high rate of economically disadvantaged citizens, with children faring the worst. Nearly 13% of the County’s children live in poverty, and 33% of public school children are eligible to receive free or reduced price lunches during the school year.ⁱ

HEALTH DISPARITIES

Health Insurance:

For all Columbia County children in 2006, 15% were uninsured and 21% were on Oregon Health Plan.

Health Risk Indicators:

Findings by the CDC in their BRFSS survey indicate that the residents of Columbia County are living with several serious health risks. The percentages of individuals living with these risks are statistically significant when compared to the data from the entire State of Oregon. The data was compiled from 2002-2005:

Survey Topic	Oregon%	Columbia County %
% who have high blood pressure	24.2%	30.9%
% who are obese (body mass index >30 kg/m2)	22.1%	30.9%
% of adults who currently smoke cigarettes	20.4%	25.9%

A 2006 study of eighth graders in Columbia County showed a preponderance of health, mental health and substance abuse risk indicators.ⁱⁱ

Risk Factor	Percentage of Columbia County 8 th Graders
No medical/physical care in previous year	48.6%
Drunk alcohol in last month	34.5%
Diagnosed with asthma	21.4%
High risk of depression	19.3%
Seriously considered suicide	16.4%
Smoked cigarettes in last month	10.2%

If left unaddressed, it can be assumed that these trends will translate to life long risk factors.

ACCESS

According to the State of Oregon’s Area of Unmet Healthcare Needs Evaluation, Columbia County is the most medically under-served county in Oregon. Columbia

County also has a Health Professional Shortage Alert (HPSA) from the Federal government.

In addition:

- There is no 24-hour, 7-days a week health care option for County residents.
- The County has only 10 full-time equivalent physicians.
- There is one Urgent Care Clinic, operating in St. Helens by Legacy Health System (LHS) eight hours per day, six days a week.
- Based on population and provider formulas, in order to adequately service Columbia County residents 4 pediatricians are recommended. Currently there is only one pediatrician and one Pediatric Nurse Practitioner, both at Legacy Health System —St. Helens Clinic.
- CHDPHA provides critical maternal and child health services along with its broader epidemiological focus. Current capacity prohibits expansion to offer primary care services.
- The closest hospital is 30 miles away. It bears noting that in 2006 hospital admissions for Columbia County residents were 17% less than expected for our population demographics, indicating that access barriers prohibit Columbia County citizens from seeking and utilizing hospital health care.
- Columbia Community Mental Health (CCMH) has 10 therapists trained to work with parents, children and families. CCMH also provides 1x/week tobacco cessation class for a sliding scale fee.
- Public transportation options are dismally limited and exacerbate the lack of access to scarce health resources. Growing fuel costs further limits access as a majority of Columbia County residents rely heavily on personal vehicle usage.

Clearly, this data highlights the tremendous need for a coordinated chronic disease prevention program

7. Statement of Readiness (10 page maximum)

i. Describe actions the LPHA has previously taken to engage policy makers in tobacco control efforts.

In 1999, CHDPHA staff worked closely with the Vernonia City Council to ban self-service tobacco machines within the City.

In 2000, the Columbia County Tobacco Prevention Coalition, staffed by CHDPHA employees, worked very hard to get the City of St. Helens to pass an ordinance banning workplace smoking exempting free-standing bars and taverns.

In FY 06-07, CHDPHA TPEP coordinator worked with the 5 Columbia School District Boards to review and evaluate school tobacco-free policies. This endeavor was the first area that new TPEP coordinator, Ederlinda Ortiz-Clawson, ventured with restored TPEP funding. As a result, the Rainier School Board passes A+ gold standard tobacco-free school policy. Three (3) school districts re-adopted B+ policies. This action has assisted in developing a working relationship with each of the districts superintendents which has since grown strong.

In December 2006, the City of Rainier declared the first week of January as, “The Great Rainier Smokeout.” This is the first of any type of Proclamation in Columbia County. This achievement was done in collaboration with the TPEP School Coordinator, Deputy Eric Bundy, at Rainier School District. The tobacco prevention and control efforts of the school and city were highlighted in area media.

During the Dec. 06 Rainier City Council discussions on the drafting of the Rainier Smokeout Proclamation, 2 council members introduced a draft City Ordinance banning the use of tobacco in the city’s park. The Rainier City Park Ordinance prohibits the use of tobacco products. Currently, TPEP Coordinator is working with the city to develop stronger education and enforcement components.

Another achievement working with policy makers, FY 06-07 TPEP Coordinator has been able to work with the Columbia County Fair Board to draft a “b-“smoke free policy with the fairgrounds. The policy includes provisions for not accepting tobacco industry sponsorship. The draft policy was tabled just before the 2007 Fair and Rodeo with speculation that the tobacco industry had derailed the policy passage. The tobacco coalition is being re-activated to take this project on.

ii. Describe actions the LPHA has previously taken to support collaboration of multiple community partners to address tobacco prevention in schools.

In a small County such as Columbia, communities tend to stay very close knit. It is critical to spend time building working relationship in order to work collaboratively on any community focused endeavor. There are several key actions that maximize our efforts to collaborate with multiple community partners; some directly and some indirectly.

Indirect

The TPEP Program Coordinator, Ederlinda Ortiz-Clawson, is also the Public Health Preparedness Coordinator. In that capacity, a high level of collaboration and partnership has been established with all 5 major cities of Columbia County. In Nov. and Dec. 2007, right before the December storm, CHDPHA successfully exercised 5 full scale public health emergency exercises that resulted in over 2500 residents receiving free influenza vaccine and over 20 organizations working together for a common cause. The planning meetings were always well attended with no less than 10 participants at each. The outreach and educational efforts for these exercises also taught CHDPHA staff many things about how to communicate and disseminate information throughout Columbia County. Strong relationships have been established with key leadership and media. In addition, the planning process for these large scale exercises afforded CHDPHA an opportunity to be “visible” in the community. So, while not directly connected with tobacco prevention and control efforts, it can be said that because of these public health preparedness exercises, CHDPHA staff has garnered trust and confidence from many key community players. Email distribution lists have grown quite large since the beginning of these planning exercises. Many of key players for community based tobacco prevention and education are the same that we’ve engaged through our public health emergency preparedness activities.

Direct

Specific to tobacco prevention in schools, communities, and health systems, CHDPHA has engaged in many collaborative efforts.

- School Health Advisory Councils: Currently there are three SHACS in Columbia County; Rainier, Scappoose, and Vernonia. These SHACS were developed through the Healthy Kids Learn Better program. We have two staff who are members of the SHACS traveling team. The traveling team model echoes the training institute outlined in the program requirements for this grant. We are confident and familiar with this model of capacity building. As team members, we complete the School Health Index (SHI) with each of the school and collectively make informed choices regarding policies, interventions, action, etc. that may positively affect overall school health. The SHI highlights areas where the SHAC may want to focus their attention. Tobacco is an area that all SHACS are working to improve. CHDPHA provides TA to that affect. Our objective in participating is to support the local planning process through technical assistance. We support school district staff by assisting with agenda development, objective drafting, training, planning/research, implementation, and evaluation. We are

- currently in the process of interpreting data, prioritization, and translating data into evidence based activities.
- School Based Health Centers (SBHC): CHDPHA was successful in securing 3 planning SBHC grants for Rainier, St. Helens, and Vernonia to support collaborative discussions regarding the creation and implementation of SBHC. Again, support is provided in the form of minutes, agenda, facilitation, editing, research, etc. We support the SBHC planning committees by encouraging community engagement and by facilitating objective focused meetings. Input and participation from schools, students, parents/guardians, community partners, and businesses are strongly solicited. Without a hospital in our County, it is critical for CHDPHA to support the SBHC agenda and attempt to address the alarming chronic disease rates demonstrated in recent BRFSS and Oregon Healthy Teen Survey. Utilizing data has enabled us to demonstrate a need for increased medical access for students.
 - Re-activation of the Columbia County Tobacco Prevention Coalition. The timing is right in Columbia County to reactivate the coalition. Disbanded in 2000, this group is ready to work on the cause again. There is so much positive media around tobacco control recently and the coalition has a smorgasbord of areas to focus on. Of particular interest is Smoke-free Multi-Unit Housing. New members have been recruited and we anticipate having representation from each of the cities in Columbia County to champion the tobacco prevention and education efforts at the local level.

CHDPHA staff understands that in order to maintain respect and trust, regular attendance and participation in community meetings is vital. In addition to the meetings noted above, CHDPHA staff attends the following meetings:

- Local Drug and Alcohol Planning Committee (LDAPC)
- Columbia Emergency Planning Association (CEPA)- all industry is represented at this meeting. CHDPHA presents tobacco related data, information, etc on monthly program report. The workplace representation at this meeting is unprecedented
- Clatskanie Together
- Periodic program updates and reports for all school districts
- Healthy Start/Headstart
- Community Action Team
- School Board Meetings
- Kiwanis Club mtgs.
- Chamber of Commerce

iii. Describe actions the LPHA has taken to support policies, systems, or environments that assist in the prevention and management of chronic diseases in the community.

The CHDPHA TPEP coordinator has over 15 years in public health and capacity building. The CHDPHA staff who coordinate and work with the community understand that it is important to evaluate where “folks” are on particular issues and to gradually, through “good” experiences, work collectively and define what will work in their communities.

With respect to the prevention and management of chronic diseases, CHDPHA has been able to work with the most vulnerable populations of Columbia County through:

- Senior Centers – Staff has connected with every single senior center and provides chronic disease management as indicated
- Residential housing/Adult Living – Embarked on smokefree multiunit housing this year. We anticipate a new member to the Tobacco Coalition
- County Jail – this is a huge achievement to be working with the Jail. There wasn't a strong working relationship but post preparedness exercises, we've been able to initiate dialogue about improving the wellness and health environment of incarcerated individuals
- Family Planning and Reproductive Health Services (FPEP) – we enroll, screen and case manage patients for the early detection of breast and cervical cancer
- Columbia Community Mental Health-Coordination of efforts with their prevention coordinator, who is also a new member of the tobacco coalition
- School Health Advisory Councils – Currently reviewing data and completing School Health Indexes (SHI), provide TA, research evidence based actions, curriculums, strategize interventions for preventing obesity, increasing physical activity, preventing/managing asthma, etc.
- Northwest Regional ESD - TPEP coordinator meets quarterly with all school superintendents to review new school laws, assist with public health related policies/procedures, maximize efforts by delegating tasks to each school districts and sharing resources such as policy language, curriculum, forms,etc.
- School Based Health Center Planning Groups – similar to the SHACs, but with the potential for having on-site medical access for students. Data demonstrates that the SBHC model works for the medically underserved communities.
- Sacagawea Health Center – coordinate efforts, attend Oversight Committee mtgs, provide data and other TA as requested
- OHSU-Scappoose – Provide TA as needed, forward compelling data, collaborate with chronic disease prevention and management. Oregon Breast and Cervical Cancer Program provider, provided latest science/medical developments, program policies/procedures, coordinated prevention and outreach efforts, case managed individuals with abnormal results
- Legacy Health System – St. Helens -Provide TA as needed, forward compelling data, collaborate with chronic disease prevention and management. Oregon Breast and Cervical Cancer Program provider, provided latest science/medical developments, program policies/procedures, coordinated prevention and outreach efforts, case managed individuals with abnormal results

An important function of CHDPHA with these planning groups/organization is to impart valuable data in a way that is relevant for each audience, introduce local and statewide resources, such as the Quitline, share evidence based activities that may “fit” with local objectives and maintain a supportive role throughout this on-going process. It is our belief and experience that this is the best way to support and sustain local efforts.

iv. Karen Fox Ladd has been the Public Health Administrator (PHA) in Columbia County for over 20 years. Despite limited resources, she maintains several key memberships in the community such as the Columbia County Commission on Children and Families. She presents annually to city officials and provides public health activities update. In addition, she meets quarterly with the Board of County Commissioners and reports significant public health developments and activities. The PHA supported community wide tobacco control planning and intervention efforts by facilitating and supporting the Tobacco Coalition, which disbanded in 2000 when funding was no longer available. She supports staff in their tobacco control planning efforts by reviewing proposed prevention strategies and providing technical support/guidance.

v. Describe how time, staff, and resources will be dedicated to the CDP assessment and planning process.

CHDPHA is committed to having a .50 FTE to work on CDP assessment and planning. TPEP Coordinator, PHA and Administrative assistant will draft job description and duties. CHDPHA will use the guidance set forth by DHS TPEP in selecting the right candidate to do this job. The TPEP Coordinator will facilitate the introduction of the CDP model to our constituents. All CHDPHA staff shall be briefed on the activities of this newly coordinated program. In essence a team will be formed within CHDPHA to address and strategize on the prevention and management of Chronic Disease. Joint meetings will be conducted to maximize tobacco prevention and chronic disease efforts. Both the TRCOD Program Coordinator and TPEP Coordinator shall work closely and organize a strong CDP traveling team. It will be essential for the TPEP coordinator to facilitate meetings with the new CDP Program Coordinator as some communities have a long standing reputation of not trusting or allowing new and innovative programs to enter their communities.

vi. Describe the process for how the County Commissioners and community partners were informed about this opportunity, involved in the decision to apply for this grant, and how they intend to participate in assessment and planning for a CDP program.

The confidence level with working the County Commissioners has improved over the past 2 years. The working bond increased dramatically during the December 2007. Post flood recovery efforts, the TPEP Program Coordinator was able to pick up the phone and call the Columbia County Commissioners office directly. A conversation detailing the funding opportunity and grant requirements were shared. She was advised to prepare a packet for the commissioners to review in their next work session. The packet highlighted tobacco related health disparities in Columbia County. The packet included the current TPEP grant objectives with a brief summary of work activities. Ortiz-

Clawson also delivered a “Save the Date” for March 6th upcoming public health planning retreat to discuss school based health center and current health indicators. Email responses from all three commissioners indicated their desire to support in anyway possible.

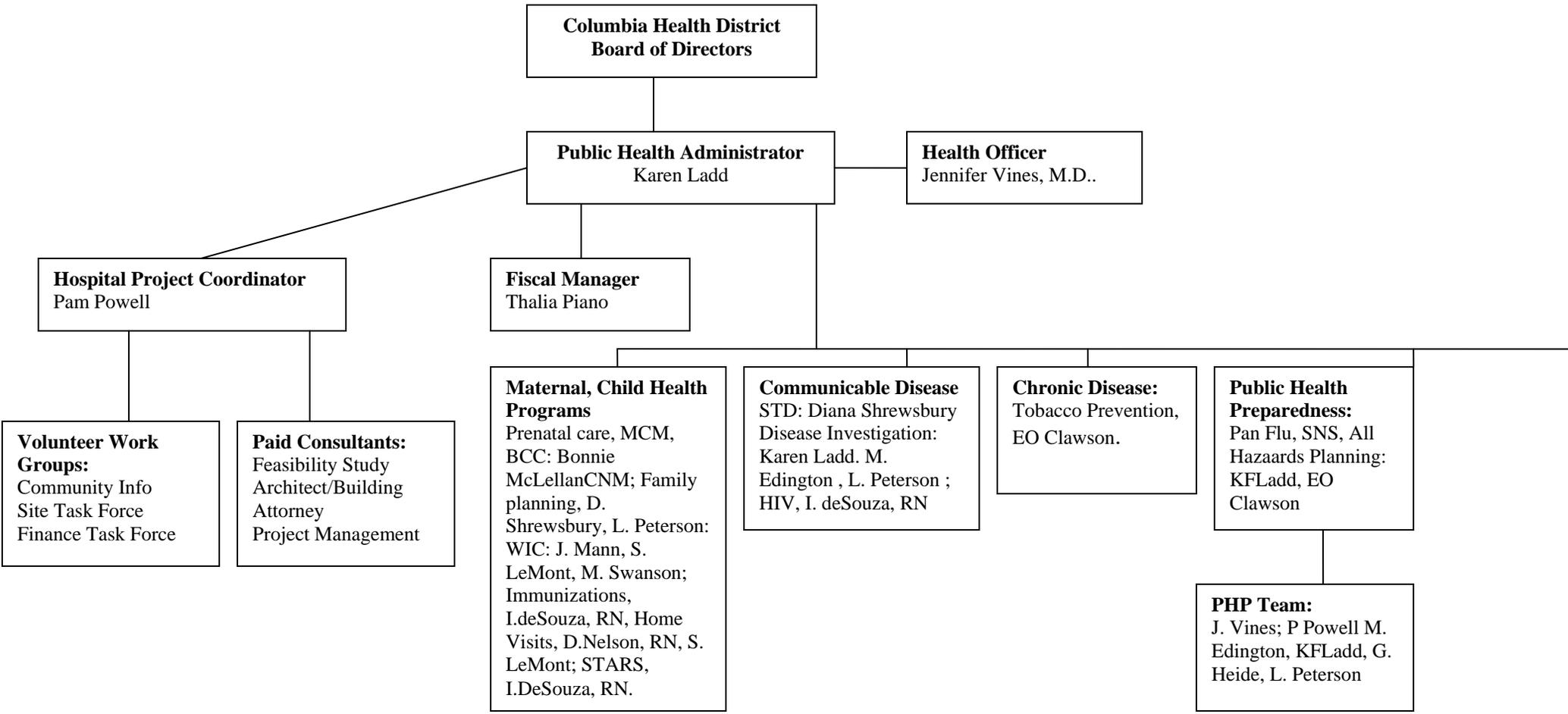
Columbia County Commissioners will be advised of all institute training dates and will be provided the findings of the community assessment as well as best –practice approaches to address findings.

An informational email went out to a distribution list of about 40 individuals detailing the scope of this funding opportunity. Again, I attached the Columbia County fact sheet as well as a sheet highlighting the statistically significant chronic disease data impacting Columbia County residents.

I also scheduled meetings or presented information at/with Columbia Community Mental Health (they conduct d&a treatment and tobacco cessation classes), Columbia River Fire and Rescue, Clatskanie School District, Clatskanie Together, Scappoose School District, Vernonia School Board, Vernonia School Health Advisory Council, Rainier School Health Advisory Council, Commission on Children and Families, and Sacagawea Health Center Oversight Committee. Overwhelming, organizations encouraged CHDPHA’s application for this funding opportunity.

Ideally, I would like to have one representative from each city to makeup the traveling team.

Thank you for this opportunity to enhance CHDPHA’s Tobacco Prevention and Control efforts and to embark on this new CDP journey with our community partners.



VII. Minimum Standards

Agencies are **required** to complete this section.

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 diseases 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.
**limited # of providers*
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 X No ___ The local health department assures that program activities reflect operation plans for provision of culturally and linguistically appropriate services.

Health Department Personnel Qualifications

103. Yes X No The local health department Health Administrator meets minimum qualifications:

A Master's degree from an accredited college or university in public health, health administration, public administration, behavioral, social or health science, or related field, plus two years of related experience.

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

104. 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.

105. 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.

106. Yes ___ No X 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.

*Dr. Jennifer Vines, our Health Officer, interned with Dr. Justin Denny for a year before he left and she was hired as the Columbia County Health Officer. She is presently working with several Metro counties and with Columbia County to obtain the required two years in practice. We have confidence in her experience.

Appendix A

Assessment Categories

- Aging Issues
- Alcohol & Drug use
- Birth defects
- Births
- Cancer morbidity and mortality
- Chronic disease
- Communicable disease
- Deaths and causes of death
- Dental
- Diabetes
- Domestic Violence
- Elevated blood lead levels
- Emergency preparedness
- Food borne illness reports
- Immunizations
- Incidence of fecal-oral transmission of disease
- Injury morbidity and mortality
- Liquid and solid waste issues in the area
- Low birth weight
- Mental health
- Physical activity, diet, and obesity
- Population by
 - Gender
 - Age
 - Race
 - Geography
 - Socio-economic status
- Premature birth
- Prenatal care
- Safe drinking water
- Safety net medical services
- Teen pregnancy
- Tobacco use
- Unintended pregnancy
- Underage drinking

Appendix B

Data Links

1. Population pyramid, by age and sex:

http://www.censusscope.org/us/s41/chart_age.html

2. Oregon population center:

<http://www.upa.pdx.edu/CPRC/publications/annualorpopulation.html>

3. Federal census center:

<http://quickfacts.census.gov/qfd/states/41000.html>

4. County facts:

<http://bluebook.state.or.us/local/counties/clickmap.htm>

5. Reportable diseases by county, and other disease surveillance data:

<http://oregon.gov/DHS/ph/acd/stats.shtml>

6. County data book:

<http://oregon.gov/DHS/ph/chs/data/cdb.shtml>

7. Chronic disease data:

<http://oregon.gov/DHS/ph/hpcdp/pubs.shtml>

<http://oregon.gov/DHS/ph/hpcdp/index.shtml>

8. Environmental Health licensed facility inspection report:

<http://www.dhs.state.or.us/publichealth/foodsafety/stats.cfm>

9. Youth surveys:

<http://oregon.gov/DHS/ph/chs/youthsurvey/>

10. Benchmark county data:

http://egov.oregon.gov/DAS/OPB/obm_pubs.shtml#Benchmark%20County%20Data%20Books

11. Local economic information:

<http://www.econ.state.or.us/stats.htm>

12. Detailed census tables:

http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=DEC&_lang=en&_ts=

13. Alcohol and Drug County Data

<http://oregon.gov/DHS/addiction/data/main.shtml#ad>

14. Web-based software for public health assessment

<http://www.oregon.gov/DHS/ph/lhd/vista.pdf>

Bibliography:

“Ambulatory Surge Capacity in Northwest Oregon,” Office for Oregon Health Policy and Research, May 2006, prepared for NW Oregon Health Preparedness Organization

“Trends in Oregon’s Healthcare Market and the Oregon Health Plan – a report to the 74th Legislative Assembly,” February 2007, prepared by the Department of Administrative Services Office for Health Policy and Research, Jeanene Smith, MD, MPH, Administrator

Oregon Benchmarks County Data, November 2005, Oregon Progress Board,
www.Oregon.gov/DHS/OPB

Oregon Vital Statistics Annual Report, 2004, Vol. 2 & Vol. 2, DHS, Public Health Division, Office of Disease Prevention and Epidemiology

ⁱ Children First for Oregon, Columbia County: Status of Oregon's Children 2006, p. 26.

ⁱⁱ Ibid.