



Deschutes County Health Department

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Local Public Health Authority

ANNUAL PLAN 2008-09



DESCHUTES COUNTY HEALTH DEPARTMENT

I. Executive Summary – 2008-09 Public Health Plan

We are pleased, once again, to provide a summary review of local Public Health services and systems and a look at the condition of health in our communities.

The Deschutes County Health Department continues to provide a comprehensive array of Public Health services which well meet assurance standards as described in OAR 33-014-055. Services including:

- Communicable Disease control and all hazards Public Health preparedness
- Family health programs, such as MCH, FP, WIC and Immunizations.
- Vital Records, Health statistics and health trend monitoring.
- Chronic Disease Services: such as the BCC Program & Tobacco Prevention
- Environmental Health Services: (via the Community Development Department)
- Environmental Toxicology Investigation and Intervention:

Key Findings and Recommendations

As in many communities across Oregon we are faced with significant health issues and health disparities due to demographic, geographic, economic and lifestyle factors. Some of the most significant of these issues in our communities that we recommend be addressed are as follows:

- Oral Health Status of low income children.
- Access to basic primary care services for low income, uninsured, Medicaid and Medicare populations – including children.
- Obesity rates on an epidemic scale affecting both children and adults.
- Health system capacity to serve bi-lingual (primarily Hispanic) families.
- Public Health capacity to address increase in prevalence of sexually transmitted infection.
- Public Health capacity to address increase in number of Communicable Disease and Food-borne illness events requiring epidemiological investigation and follow-up.
- Public Health capacity to address chronic disease via prevention, education and policy initiatives.
- Health, social and economic impact of Methamphetamine abuse.
- Low Immunization rates for young children.
- Drinking water quality preservation in Southern Deschutes County.

The 2008-09 Plan also recognizes notable progress made and sustained in several key areas:

- Low teen pregnancy rates.
- Low School Exclusion rates for school age immunization.
- Added Capacity across the Primary care safety net system.
- Exceptional Breastfeeding rates among Deschutes County WIC mothers.
- School Based Health Center in La Pine and planning for two additional sites.

The Deschutes County Public Health Department recommends continued focus on the long list of health issues challenging our communities and families. We strongly endorse enhanced State financial support for activities related to Disease Control and chronic conditions to address the unique health needs of special populations. The Department enjoys the support and active participation of our local Public Health Advisory Board, our Board of County Commissioners and a strong collegial relationship with our State Public Health partners as well as many local coalitions and agencies.

II. Assessment

Community Health Assessment

Community Health Profile – 2007

In March of 2007, the Department issued its third edition of a Community Health Profile Report. A PDF version of the report is noted as **Appendix A**. The report summarizes the major health issues and trends across Deschutes County. Please refer to the report for a comprehensive assessment of the Health of the Community. The Department will continue to support the collection of health data and reporting in this format on at least a bi-annual basis. In addition to the findings in the report, a few of the major health issues affecting our Communities are noted below.

Access to Health Care / Safety Net Health Services

Access to basic primary, dental and behavioral health care and medical services remains one of the foremost needs across our communities. In reality, a crisis has arrived. It is estimated that 25,000+ Deschutes County residents lack any form of healthcare insurance and are disenfranchised from the Health Care System. At 19.1% Central Oregon has the highest uninsured rate in the State. Some **6,300** Deschutes County children remain uninsured. It is estimated that some **13%** of our children live below the poverty line. It is uneasy knowing these are many of the children facing the most significant health and dental issues. As of March 10, 2008 **2,860** Deschutes County Residents had applied for the new OHP Lottery expansion.

On note are that 92% of all Central Oregon employers employee less than 20 personnel making the purchase of group insurance unaffordable for most.-2007 statistic?

A significant percent of the uninsured are the working poor as well as Hispanic families who have migrated to the region in recent years. In safety net services, it is not uncommon to find the medically disenfranchised have gone many years without care and present with advanced health conditions that might have been easily treated or avoidable had they been able to access health services earlier. These problems present a considerable challenge in the safety net care setting.

Since 2003 we have also seen an increasing barrier to health care services for those insured individuals who have a Fee-for-service Medicare or OHP coverage. This form of insurance is by no means a guarantee to health care services. An ever increasing number of physicians and practice groups are limiting and even refusing to see and treat clients with these forms of insurance, citing low reimbursement rate as the culprit. Added together, we estimate some 33,000+ residents, adults and children, face serious economic barriers and greatly limited access to primary care services and are likely to struggle to find a medical home. One glimmer of good news is that a Rural Health Clinic in La Pine has remained committed to serving that community. There is currently a discussion between this Rural Health Center and the Ochoco Health System (FQHC) to explore opportunities to

collaborate to better serve the La Pine Community. Also significant is the recent incorporation of the La Pine Community. We trust this will only help in working with members of this community to address current and future health care needs.

In September of 2003, a private clinic in La Pine was given the designation as a Rural Health Care Clinic. This designation has assisted the clinic with its financial stability, due to higher reimbursement rates. In April of 2004 a new health care clinic called the Volunteers in Medicine Clinic of the Cascades (VIM) opened its doors, providing an access point for low-income, uninsured residents of Deschutes County. The VIM clinic delivered over **7,500** patient visits in 2007.

The Ochoco Health System expanded their FQHC network to Bend and Madras in 2005, bringing much needed access to Medicare and low income clients. The Ochoco Health System delivered over **20,000** patient visits across Central Oregon in 2007. The School Based Health Center in La Pine continues to thrive as a critical access point to health services for many of the school age youth in southern Deschutes County. The clinic is unique in Oregon in that it readily serves all school aged students K-12. The FAN (Family Access Network), Wellness Program, co-sponsored by local schools and the Deschutes County Health Department continues to provide care to approximately **1000** children annually, but will merge with the new School Based Health Centers, should they open in the Fall.

(Note: The FAN wellness clinics will be discontinued in school year 2008-2009 due to the decrease in Medicaid Administrative Claim federal funding to the schools. Deschutes County plans to enroll these students with difficulty accessing medical care into the new school based health centers planned in Bend and Redmond.)

Childhood Chronic Disease

Childhood Asthma, Diabetes and Obesity are drawing increased attention at the local level. A coalition has been formed called *Healthy Active Central Oregon (HACO)* to identify and implement strategies aimed at addressing inactivity and obesity. The Oregon Healthy Teens Survey reveals that **19.5 %** of our 8th graders and **18.6%** of our 11th graders are overweight. There has been a startling rise in obesity rates in children in the past two decades.

Communicable Disease

The Communicable Disease Program in Deschutes County continues to grow with increased numbers of disease cases, food-borne outbreaks, and requests for information from the community. The County population growth has increased from 115,367 in the year 2000 to over 162,000 in 2007. Chlamydia continues to be the highest reported disease in Deschutes County, with a **69% increase** in the since 2001. The cases count for 2007 was 395. Overall, Communicable Disease reports and investigations have increased over 500% since 1998 creating an increased workload on staff for follow-up. The Department investigated 7 cases of Gonorrhea in 2006, and 3 cases of early syphilis.

Deschutes County continues to have higher rates of Giardiasis, the number of Campylobacter continues to rise, and the number of food-borne illness outbreaks (Norwalk) have increased. Deschutes County is also averaging **20-25** cases of Hepatitis C a month (non-acute) and, since the disease became reportable in 2005, has created an unfunded workload for staff.

It has been a challenge in the local medical community to develop an effective reporting loop with providers in the community. Due to high provider turnover and a large influx of new providers the

CD team has found it difficult to educate and remind about reporting standards on a regular basis. In 2007 presentations were done for the emergency room medical staff in hopes of improving the frequency of contacting the health department about reportable diseases.

The Communicable Disease (CD) team updated the West Nile Virus Plan, implemented surveillance in 2005, and is preparing for the Spring of 2008. The CD team completed development of a SARS Plan; is in the process of updating the Pandemic Flu Plan for 2008; as well as participating in health system preparedness with Cascade Health Systems and numerous community partners.

Cultural Competency

Those of Hispanic origin are a fast growing group as indicated by the fact that over 9% of all 2006 births were to Hispanic mothers. Many of these families are non-English speaking and require translators to ensure they receive safe, effective care and services. Hispanic mothers have good access to prenatal care regardless of their insurance status through HealthyStart Prenatal Clinic. The service also offers childbirth and car seat safety classes in Spanish. Translation and cultural needs for Hispanic mothers are also well met in the WIC program.

The Reproductive Health programs, including Family Planning and STD, have front office and clinical staff who are bilingual. An interpreter is available for clinicians who do not speak Spanish. All educational materials and forms are available in English and Spanish. The clinic uses a certified translator to translate or review all Spanish materials. The staff has had cultural competency training and works very hard to meet the needs of all cultures that access services at the Health Department. In February 2008, we started a "Males Only Clinic" and have marketed services toward Men Who Have Sex with Men (MSM). The staff who work this clinic are well trained in the needs of this community. Deschutes County is committed to providing equal access and eliminating barriers to care for all clients.

Demographic Population Changes

The County is challenged by a rapid population growth in terms of keeping pace with the increased demand for Public Health services. Deschutes County, again, ranks near the top in per-capita growth rate for 2007. The County Population at the end of 2007 is estimated to be over 162,000 citizens. The increased demand for prenatal services relative to the growth in the Hispanic population is noteworthy. **Of 2000 live births in 2006, 234 (11.7%) were to mothers of Hispanic ethnicity.** In 2006 the HealthyStart Prenatal Service (our safety net prenatal program) assured for the delivery of 182 healthy babies. All but 20 were to Hispanic mothers.

Of note is the rate of growth in our over 65 senior population. Estimated to be 19,988 persons in 2006 (13.1% of the population) this figure is expected to grow to over 27,000 by 2010 and over 45,000 by 2025 a 143% increase from 2005-2025.

Emergency Preparedness

Program staff have developed a Pandemic Flu Plan, collaborated with community partners, and incorporated the plan into the County Emergency Response Plan. DCHD continues to work with the County Emergency Manager to plan County exercise revision. The program hired a full time coordinator in the Spring of 2007 and since that time has made notable progress in staff training as well as community and health system readiness.

Environmental Health & Toxicology

In southern Deschutes County efforts to assure for the preservation of the quality of drinking water from groundwater sources has received acute attention. A recently completed US Geological Survey indicates nitrates will continue to accumulate in the shallow water aquifer unless remediation efforts are undertaken. The County is still considering adopting new development code that would address nitrate sources from septic system effluent. Citizens regularly contact the Health Department with concerns related to environmental toxicology. We anticipate more attention to health effects from West Nile Virus in 2008, given we had our first avian case in late 2006. We added a part-time position to the Department in the Spring of 2008 to help address these growing areas of concern.

Family Violence

Family violence includes child abuse, domestic violence (intimate partner violence), sexual assault, and elder abuse.

Child Abuse: In 2001, the reported child abuse case rate in Deschutes County had increased from 10.8 to 11.6 and was considerably worse than the Oregon rate. (344 substantiated victims) The rate decreased to 9.4 in 2002 – **(292 victims)**, fell further to 8.8 in 2003 – **(282 victims)** and lowered to 8.2 in 2004. – **(276 victims)** but remember the loss of public staffing dedicated to this area of concern. In 2003 there were approximately 1800 calls to the local DHS Child Abuse Hot Line. **The State of Oregon Benchmark for 2005 was 6.2 confirmed cases per 1,000 children.** If we were to achieve this benchmark then we would expect to **avert 83 children from suffering as victims of reported and substantiated child abuse** - based on a child population of 31,926 for 2004.

Unfortunately, the rate of confirmed child abuse in Deschutes County in 2005 was up 16% over 2004. The rate in 2005 is 9.6 per 1,000 children. In 2005 there were 32,821 children under the age of 18 in Deschutes County. This translates to **314 cases of confirmed child abuse in 2005.** In **2006** there were **2663 reported cases of child abuse in the tri-county central Oregon area.** Of these apx. 2/3 were from Deschutes County. While the “substantiated” case rate for 2006 lowered slightly to 9.0 cases per 1,000 children – **216 substantiated cases of abuse out of 758 investigated cases** it is worthy to note that Child Protective services is only addressing cases where the child is believed to be at imminent risk of harm.

Social service workers state that the number of reports of abuse children has not decreased much over time, even though the numbers might suggest this. The lower case rate numbers may well reflect a tightening of the definition of confirmed child abuse. DHS tightened the definition of a founded/confirmed child abuse case, specifically in the area of "threat of harm." The end result has been a lower number of founded cases as compared to previous years.

It is worthy to note there has been a significant increase in children ages 0-2 who are born to parents with known substance abuse problems, especially methamphetamine. A recently completed *Healthy Teens Survey* revealed that 20% of Deschutes County 11th Grade Females have been victims of sexual contact from an adult at some point during their life.

Domestic Violence: In 2001, an estimated 762 women and 489 men (1251 total) were subjected to physical violence by an intimate partner. For 2002, the local women’s shelter for battering and rape reports 302 women were sheltered for a total of 4,894 nights and there were a total of 2,624 hot line calls. In 2003 the numbers increased to 386 women and children sheltered for a total of 4,086 nights and 3,311 hot line calls. In 2004 the numbers leveled off somewhat to 320 women and children sheltered for 4,072 nights and 2, 704 hot line calls. Current community factors that impact the

problem include increasing unemployment, lack of basic family resources for a growing number of people (putting greater stress on the family unit), a growing Hispanic population with cultural acceptance of Intimate Partner Violence (IPV), and a growing problem of methamphetamine use.

The Health Department received a \$4,700 grant to improve the screening, reporting and referral process with our clientele. This will provide the resources to enhance the current level of service we are providing in this area, and will be complete by the spring of 2009.

Food-Borne Illness Reports

2007 witnessed a number of reports of institution-wide Norovirus outbreaks.

In 2007 we saw 18 Salmonella cases, compared to 12 in 2006. There were 14 outbreaks reported in 2007, compared to 11 in 2006. 2006 and 2007 witnessed a number of reports of institution-wide Norovirus outbreaks perhaps due to increased surveillance. The coordination between Public Health and Environmental Health is positive and has resulted in the formal assignment of Environmental Health service into the Public Health Department, which began July 1, 2007.

Health Officer

In the Fall of 2006, the Department matured the vision and scope of the traditional Health Officer role by securing the services of three Medical Directors. Dr. Richard Fawcett, an infectious disease physician was named Health Officer and Medical Director of Communicable Disease Services. Dr. Mary Norburg, an OB/ GYN physician was named Deputy Health Officer and Medical Director of our Maternal Child Health Services. Dr. Steve Knapp, a family practice physician was named Deputy Health Officer and Medical Director of our Pediatric and Juvenile primary health care services. To date, this model has been working famously well.

Immunizations

Despite providing immunization to nearly 9,000 children in our shots-for-tots program, the rate for Deschutes County overall **fell to last in the State with barely at 51% of our two-year olds fully covered with recommended vaccines**, in 2005. In 2006 the Department improved the immunization rate for its 0-2yr old, service population to **66%**, off slightly to **64%** in 2007. 2008 will bring an acute focus to this issue and an affirmative plan to increase our rates. The program recently made significant progress by working with Central Oregon Pediatrics Associates to install the ALERT Immunization registry. We anticipate that this will help capture more accurate immunization status data and alert practitioners to the opportunity to vaccinate their young patients.

Injury Morbidity and Mortality

Injury remains the leading cause of death among Oregon's Children aged 1-17, and young adults up to the age of 44. Injury is the 4th leading cause of death overall if all age groups are combined. Among all age groups, unintentional injuries resulted in 47 deaths in 1998, 45 in 2000, 43 in 2001, 56 in 2003 and **58 in 2004**. Most injury related deaths occur as a result of motor vehicle accidents (38%), falls (29%), poisoning (10%), drowning (3%), firearm shootings, fires, suffocation and water transport incidents. Injuries are not "accidents," in that "injuries" can be predicted and prevented. The 2000 HRSA Community Health Status Report indicated that Deschutes County's rate of Motor Vehicle Accidents (MVA) to be **26.1** compared to a National Rate of **15.8** (1997 Data). HRSA data reveals that **313** injuries were from falls, **135** from MVA, and **40** from other methods of transportation.

Lactation Services

The Department is deserving of notable recognition for programs that address breastfeeding including MCH, WIC (Women and Infant Children), Prenatal Care Clinic, and Oregon MothersCare. The agency seeks to improve coordination among these services for the purpose of consistency for clients as well as maximizing resources. A chief strategy is the revision of the WIC Breastfeeding Coordinator position to incorporate a leadership component to facilitate coordination and to provide shared training to all staff who provide breastfeeding services. The breastfeeding initiation rate among Deschutes County WIC clients is 94.4% based on 2007 data from CDC (Centers for Disease Control and Prevention). This data ranks Deschutes County as third highest among all Oregon WIC agencies.

Leading Causes of Death 2005 – Deschutes County (1062 deaths)

1. Cancer – 23.7% (252)
2. Heart Disease – 22.6% (240)
3. Cerebrovascular Disease – 6.8% (72)
4. Unintentional Injuries – 6.3% (67)
5. Chronic Lower Respiratory Disease – 5.9% (63)
6. Diabetes -3.4% (37)
7. Alzheimer’s Disease - 3.4% (36)
8. Suicide – 2.2% (23)
9. Alcohol Induced Deaths – 1.7% (18)
10. Parkinson’s Disease – 1.2% (14)
11. Flu & Pneumonia – 1.2% (13)

*** Note: Tobacco use contributed to an estimated 218 deaths in 2005**

Medical Examiner - Coroner

The Deschutes County Medical Examiner is housed within the office of the District Attorney for criminal investigative work. Other work is coordinated between the State Medical Examiners office and the local Medical Examiner. The Medical Examiner is playing an increasingly important role in our Public Health System. A Medical Examiner, Dr. Chris Hatlestad, was hired in the Fall of 2003 and has demonstrated a strong interest in working collaboratively with the Health Department on health trend analysis and deaths of Public Health significance. Thanks to Dr. Hatlestad’s keen observations we recently identified a death related to Hantavirus. Dr. Hatlestad is also an active participant in our Health system effort to prepare for pandemic flu and participates regularly in local Child Fatality Review Board meetings.

Mental Health Services

The National Institute of Mental Health estimates that 26.2% of Americans 28 and older (1 in 4 adults) suffer from a diagnosable mental health disorder in a given year. When applied to the 2006 population estimate this figure translates to over 30,000 Deschutes County residents. While resources for Mental Health assessment and treatment have diminished, Deschutes County is strong in provider partnerships which enhance the efficiency of existing services through coordination efforts.

Substance Abuse - Methamphetamine use is on the rise and difficult to intervene. A local grass roots effort called the *Meth Action Coalition* has achieved tremendous community and business recognition of this devastating substance abuse.

Oral Health

Tooth decay remains the #1 most common chronic disease in children age 5-17 – five times more common than asthma. Children from low income families have nearly 12 times restricted activity days due to the pain and suffering of tooth decay than do their counterparts from higher income families. Between 2005-2006 32.6% of Deschutes County 8th graders reported not having a visit to the Dentist, higher than the State-wide rate of 26.3%.

These same populations also have barriers to obtaining dental care including extremely limited safety net services, limited numbers of local dentists who accept OHP and of those who do limited capacity to cover the total plan enrollment for the region. A local safety net dental clinic reports they see an average of 50 uninsured school age children per month. Local emergency rooms report a significant number of visits for complications of untreated dental problems. Area safety net care clinicians believe they see very high rates of advanced caries in low-income children. Many OHP enrollees report being assigned to dentists who are out of the area making it difficult for them to access care. Local dentists report low income and OHP populations are difficult to serve because of higher levels of dental problems and complications poorly covered by OHP.

Limited screening for children is provided in Well Child Clinics as well as nurse home visiting programs. Eligible families may receive prescriptions for fluoride through Well Child Clinics and extensive prevention education is offered in all MCH programs including WIC. Pregnant women receive minimal screening and referral or case management to access a dentist.

The OHP population of pregnant women served in Maternity Case Management (MCM) services have been identified as having high rates of dental problems and poor access to care. Participation in local oral health initiatives such as a new Coalition and a prevention project in WIC have led to improved access to dental care as well as a better system of providing oral health prevention messages to pregnant women. The Oral Health Coalition continues to provide leadership in advocating for underserved populations in Deschutes County, and in 2005 developed teaching brochures to use with high risk populations. The brochures continue to be distributed through DCHD clinics, home visiting, WIC and the Ready Set Go program.

The Coalition received training in the Cavity Free Kids program and is now using volunteers to distribute the training into community partners (Head Start, WIC, Ready Set Go, and in MCH home visiting programs). The coalition has assisted VIM (safety net clinic) and the community college in development of an adult dental clinic staffed by dental hygiene students and volunteer dentists. Give Kids a Smile day was very successful in helping young children access free care this year. Currently, the coalition has developed a protocol to inform new dentists of the coalition. DCHD received a grant from ODS to provide materials and fluoride for a dental screening program to be staffed by PHNs (Public Health Nurses) to provide referral, education and fluoride varnish to children referred through WIC. Northwest (NW) Medical van is being scheduled through VIM (Volunteers in Medicine).

Despite 50 years of scientific and medical research on the health benefits of community water fluoridation, every city in Deschutes County remains unfluoridated.

Prenatal Services

Deschutes County has developed a strong Perinatal Service system involving multiple community partnerships. A shared value among partners is prioritizing early access to prenatal care for all

pregnant women regardless of income or insurance status. A highlight of this system is the partnership between the local hospital and the Deschutes County Health Department to provide a safety net prenatal care clinic for uninsured pregnant women, known as the *HealthyStart Prenatal Service*. The elements of the system are interdependent and reliant on each other to make an optimal contribution to the continuum of need for pregnant women and their families. Our rapidly growing population is challenging the ability of providers and services to sustain the quality of the existing system.

There were **2,000** live births in Deschutes County in 2007. Of them, **187** were births whose moms enrolled in the *HealthyStart Prenatal Program*. Of note is that 156 of the *HealthyStart* births were to Hispanic mothers. *The HealthyStart Program* processed and assisted **659 program** participants with their application for the Oregon Health Plan. – apx 1/3 of all births in Deschutes County.

The Deschutes County HealthyStart Program was chosen to be one of two pilot projects for the Perinatal Expansion program which allows CAWEM (Citizen Alien Waived Emergency Medical) eligible pregnant women to be enrolled in CAWEM Plus. This program provides prenatal coverage through a County match via SCHIP funds. The pilot program will extend for a 15 month period.

96.8% of pregnant women received adequate prenatal care in 2005 with 90.3% starting care in the first trimester. The rate for starting prenatal care in the first trimester has increased from 83% since the implementation of Oregon MothersCare in 1999. 12.9% of pregnant women in Deschutes County reported using tobacco in 2004. The low birth weight rate was 6.6%. Infant mortality was 6%, up from 1% in 2001.

Suicide

Sadly, suicide is the second leading cause of death among Oregon youth age 10-24. In Deschutes County there were 18 confirmed youth (10-17 year old) suicide attempts in 1999. That figure rose to 63 in 2003 prompting community-wide attention and discussion. There were 42 confirmed attempts in 2004 and **42** again in 2005. While 2/3 of youth suicide attempts are among females, 82% of youth suicide deaths are among males. For every suicide death among youth under the age of 18, there are an estimated 134 suicide attempts that are treated in hospital emergency rooms. Suicide for all ages accounted for 24 deaths in Deschutes County in 2002, 21 in 2003 and 24 in 2004 and 23 in 2005.

In 2006 The Health Department attempted to launch the *Connecting Youth* pilot project to prevent second attempts of suicide in children under 18, unfortunately this program failed to launch due to concerns raised at the local hospital over patient privacy rights. The program was disbanded in the Spring of 2007. Some have been trained in using C-CARE and P-CARE tools developed by the University of Washington. Children and their families will be referred through the emergency rooms and schools. A Public Health nurse will visit the families and youth, using interview techniques and tools. Unfortunately, reluctance on reporting to the local Health Department has hampered this potentially beneficial project.

Unintended and Teen Pregnancy

The Deschutes County Health Department (DCHD) plays an active role in implementing the Oregon Teen Pregnancy Action Agenda. The teen pregnancy rate (per 1000 Females aged 10-17) in Deschutes County has decreased from 17.9 in 1996 to **8.6 in 2006**. The rolling rate for teen pregnancies in the 10-17 year old age group for 2007 was **7.7**. This is in large part due to the diligent work of Public Health staff and their collaboration with community partners that assures access to reproductive health education and services.

Each year the Health Dept., in collaboration with the schools, provides the STARS program to almost 1,300 middle school students with over 150 high school volunteers as mentors. Our health educators have taught over 80 classes on reproductive health to over 2000 students in middle schools, high schools, and at Central Oregon Community College within the past year. They have incorporated important components like health relationships and communication into their presentations to make the curriculum more comprehensive.

We have had the Male Advocates for Responsible Sexuality (MARS) Program for the past 3 years and have taken an active role in male involvement issues. We have offered parent educational opportunities for the community on an annual basis.

Deschutes County Health Department Family Planning Clinic places emphasis on avoiding unintended pregnancies. The Deschutes County Family Planning Program provided services to 3,790 unduplicated clients in 2007. 968 of these clients were between the ages of 10 and 19. It is estimated that these services have averted 624 pregnancies. To make services accessible for Deschutes County clients we maintain full-time clinics in both Bend and Redmond. We also serve clients in La Pine two Thursdays a month and operate a clinic called the Downtown Health Center for clients 25 and under 2 ½ days a week.

Adequacy of Public Health Services ORS 431.416

The Deschutes County Health Department provides quality service at an adequate level of capacity, given the resources provided through local public funding, Federal/State grants, and billable revenue. The Department continues to face increased demand for required services at a faster clip than resources can match. This is particularly challenging in our Communicable Disease cluster of programs where State funding remains weak and the expectations surrounding epidemiological investigation and follow-up are high. Our MCH Division (Maternal Child Health) of services suffers much the same fate, where despite excellent talent and skills across the team, the demand for services outpaces capacity nearly 2:1. The Department provides exceptional services in its WIC, MCH, CD, FP and EH Divisions. The Department will work to improve the efficiency and the cost profile of Family Planning services in 2008, and will address community-wide Public Health Preparedness with renewed vigor.

The Department has added a new emphasis in Health Promotion and Chronic Disease Prevention by clustering Tobacco, Asthma and Obesity prevention efforts under one roof. The Department continues to be in need of capacity to address issues related to environmental toxicology and the link between environment and human health.

Provision of Basic Public Health Services

The Department provides the five basic services outlined in statute (ORS 431.416) and related rule. OAR Chapter 333, Division 14:

1. Epidemiology and Control of Preventable Disease and Disorders

The minimum standards for Communicable Disease Control are met and the system for enhanced Communicable Disease control has improved. With the increased population and preparedness

requirements, the need for additional staff is great. The Communicable Disease Program responds 24/7 to information requests and currently sends a request to physicians who report Hepatitis C for permission to send educational information to the client. The program provides blood-borne pathogen training throughout the County and Hepatitis B vaccines for occupational purposes.

The Communicable Disease (CD) team pulls together to offer Tuberculosis screening and testing to various local partners in the medical community and first responders. In 2007 the TB coordinator focused on screening our homeless shelters. Blood borne pathogen outreach training is facilitated on request when staff is available.

In the Fall of 2007 seasonal influenza surveillance began. Data collected from provider testing through local clinics and hospital staff has given DCHD a better picture of the effects of seasonal Influenza in the community, as well as enhancing our ability to share local statistics with the public.

The Communicable Disease team collaborates regularly with the media to prevent the spread of both well-known and novel diseases in our area. The team works to ensure that education is both available for the community when sought after, as well as working with local media to be pro-active with public education around topics such as tuberculosis, MRSA, Influenza, etc.

The minimum standards for Communicable Disease Control are met and the system for enhanced Communicable Disease control has improved. With the increased population and preparedness requirements, the need for additional staff is great. The Communicable Disease Program responds 24/7 to information requests and currently sends a request to physicians who report Hepatitis C for permission to send educational information to the client. The program provides Blood-borne pathogen training throughout the County and Hepatitis B vaccines for occupational purposes.

The program currently:

- Has a Communicable Disease Program Manager, CD Coordinator, CD Health Educator, STD/CD backup RN, Immunization Coordinator, Public Health Preparedness Coordinator, HIV Case Manager, and support staff.
- There is a mechanism in place for 24/7 calls for Communicable Disease reporting and Public Health emergencies.
- Evaluations of facilities implicated in a food-borne outbreak are assessed by Environment Health working in close collaboration with CD team staff. The Environmental Health Licenses Facilities Division transferred into the Public Health Department on July 1, 2007.
- Investigations are completed in a timely manner, control measures are taken, and reports are completed, and sent to the State in the specific time frame.
- Access to prevention, diagnosis, and treatment services to protect the public.
- Communicable Disease trends are evaluated on a regular basis by the CD team and objectives are developed.
- Immunizations are provided to the public.
- A needle exchange program launched in early 2007.
- Rabies immunizations are provided in the jurisdiction.
- The program has generic press releases for outbreak information.

2. Parent and Child Health Services

Perinatal Services:

Prenatal Care Access

Reestablishment of the Oregon MothersCare system has resulted in significantly more OHP enrollments. Our Oregon MothersCare staff was reduced to .4 FTE in 2006 yet still served 577 women in 2007, with 90.4% receiving prenatal care in the first trimester and 66.0% of late contact clients started prenatal care within two weeks of initial contact.

This function works in close collaboration with our own *HealthyStart Prenatal Service* - a safety net clinic where low income women who are ineligible for OHP can and do receive high quality prenatal care and birth delivery services. This County-Hospital Program has now reached capacity, having served over 300 women in 2006 and performed 182 birth deliveries. The Program will be challenged in meeting the needs of Hispanic and non-English speaking pregnant women. A shortage of qualified translators makes it difficult for these women to get comprehensive services. **A new opportunity exists with the CAWEM-OHP eligibility pilot project. The Department intends to participate in this new project effective April 1, 2008.**

Dental Care - While OHP enrolled pregnant women have coverage for dental care; most area dentists refuse to provide care during the pregnancy. Home visiting nurses estimate that nearly 97% of women on their caseloads have serious dental problems yet are unable to access care. Our local Dental Plan (Northwest Dental) is in the process of carrying out a training agenda for participating dentists with the objective of increasing dental care provided during pregnancy. Significant improvements have occurred with access to care and prevention efforts (see Oral Health Section).

Case Management and Social Services - Nurse Home Visiting - Decreasing ability to meet demand due to decrease in capacity. Service would be in jeopardy if Medicaid reimbursements decrease. Population growth has caused demand for services to greatly exceed staff capacity. Currently staff cannot handle all high risk referrals.

Intimate Partner Violence - Services are limited to local shelter and lack an outreach/ education component.

Mental Health Services - Severe loss of capacity for low-income pregnant women due to cuts in County Mental Health services.

Alcohol and Drug - Severe loss of capacity for case management and treatment due to cuts in County Mental Health and Child Welfare programs.

Tobacco Cessation - Inadequate resources for tobacco cessation for pregnant women. LHD Smoke Free Mother Baby project is limited and the only service available. It is noteworthy that **nearly 40% of OHP mothers smoke** during their pregnancy versus 11.2% of non OHP moms.

Breastfeeding Support - Losing capacity for in-home nurse visiting service, but remaining strong in WIC and local hospital outreach programs. Improving with better coordination among perinatal services and the addition of the WIC Breastfeeding Peer Counselor Program.

Multicultural Service - Growing need for translators and Hispanic service will increase the gap between need and capacity as medical and human services experience shortfalls in resources.

Child Health Services

The Health Department provides education, screening, and follow-up for growth and development, hearing, vision, lead, and symptoms of illness for high-risk infants and children. These services are provided through safety net primary care and nurse home visiting. Additionally, we provide assessment of parent/ child interaction (NCAST) and SIDS follow-up. The demand for screening and follow-up of high-risk infants (Babies First) exceeds capacity. Approximately 40% of current referrals will not receive services. Coordination of community services has decreased leading to inconsistency of referrals from partners and making it difficult to track needs.

La Pine School Based Health Center

Deschutes County in its fourth year with a fully certified School Based Health Center (SBHC) serving grades K-12 in La Pine. This new service will add capacity to the community's safety net care system and will provide access to primary care for approximately 1,500 La Pine school students. **Planning is underway to hopefully open new SBHC's in Bend and Redmond in the Fall of 2008.**

Children with Special Health Care Needs

Children with physical, cognitive, and social disabilities are case managed by a MCH nurse specialist. The LHD contracts with Child Development and Rehab Center to provide the CACOON program.

The MCH program continues to participate in a Telemedicine project funded through CACOON to allow Deschutes County special needs children to receive consultation from specialists via teleconferencing.

Family Planning Services – ORS 435.025

Deschutes County Health Department maintains four family planning clinic sites to serve multiple areas of the County. We have two full-time clinics in Bend and Redmond, a clinic in LaPine 2 Thursdays a month and for the past 2 years we have been serving youth and adolescents up to age 25 at the Downtown Health Center. The clinics provide reproductive health services under the Title X program guidelines and contraceptive services under FPEP. All clinics provide care under protocols and standing orders approved by the Medical Director, Mary Norburg MD.

All Family Planning staff meet on a regular basis to discuss program updates, case studies, and information exchange. The program delivered service to 3,790 unduplicated clients in 2007 and averted 624 pregnancies. In 2007 we saw a decrease in clients served by 14.7% when the statewide decrease in clients served was 19.6%. One of factors affecting our decrease is that starting fiscal year 2007 we separated our FP and STD programs. Clients for STD services were no longer being seen under the Title X guidelines and we imposed a minimum fee for STD services.

Like many Family Planning services across the State ours too faced substantial financial challenges in 2007. The increase in non-FPEP clientele and the rapid increase in pharmaceutical cost have thrown a true financial curve ball at the program. Attempts to manage patient mix and verify income for placement on the sliding fee scale have been met with stiff resistance in the face of Title X regulations. In economic terms the stiff Title X guidelines result in a significant lost opportunity cost for those clinics who can foresee options to manage income/ revenue as a means to maintain service level verses being faced with service reductions.

The registered nurses working in reproductive health are required to complete a very comprehensive training program and have NP back-up available. The support staff are given training materials on the fundamentals of family planning that are based on up-to-date research and current guidelines. The training modules focus on birth control methods, anatomy and physiology, and STDs as well as communication skills, informed consent, and client education.

We use a broad range of client education materials many of which we have developed ourselves to meet the educational needs of the clients and are reviewed by our FP Advisory Committee. The materials are kept current and are available in Spanish and English. Materials are selected or developed for prevention as well as for education regarding specific conditions.

Our Family Planning community outreach and education has grown in the past several years. We have several health educators who actively participate with community partners. They attend the school districts Health Advisory Board meetings and are playing an important role in helping the school district come into compliance with the sexuality education guidelines.

3. Collection and Reporting of Health Statistics

Vital Records work related to birth and deaths are well organized, highly accurate and extraordinarily efficient thanks to a small staff of highly trained and dedicated professionals. The local Medical Examiner is now compiling and sending information to the Local Health Department on deaths of Public Health significance and assisting in monitoring trend data related to injury and death related to illicit drug use. Collection of vital statistics and Communicable Disease information is received and recorded in a timely manner.

The Communicable Disease information is forwarded to the State through the new CD database and immunization data-entry is completed daily. The number of births and deaths continue to increase related to a rapid increase in overall County population. In the past two years we have witnessed an explosive rise in birth numbers.

There were 2000 live births in 2006; 1,783 live births in 2005 and 1,438 in 2000, revealing our upward trend. This represents a 25% increase in birth numbers over the most recent 5 year period. There were 1,202 deaths recorded in 2005 compared to 916 in 2000. This represents a 32% increase over the 5 year period. The Department issued an updated Community Health Profile report in March of 2007. (Appendix A)

Deschutes County once again earns the distinction of being Oregon's fastest growing County per capita. According to Portland State University's Center for Population studies Deschutes County's Population was estimated to be over **162,000 in 2007** as compared 116,600 in **2000**. This represents a **30% increase**. Current population forecast project the County population to increase steadily to 170,800 by 2010 and near 250,000 by 2025. **22.5% of our population or 34,318 individuals are under the age of 18.**

Local partners have become increasingly reliant upon up-to-date and accurate population and birth forecast information for program and facility planning purposes. The Department has improved access to vital statistics through links in its own website. Reportable disease has increased consistently with increased population and improved communication with local physicians and laboratories.

Recently, the Department has worked to inform the community of the condition of health across the community. This has been done by producing bi-annual Community Health Profile reports and also by selectively profiling the specific health issues, such as Obesity, Access to Primary Care, and the Oral Health condition of Children. **The 2007 Health Profile report is attached as Appendix A.** Currently the Department is engaged in a collaborative community effort to profile the incidence and impact of Methamphetamine abuse across our communities.

4. Health Information and Referral

Health information and education is provided through Deschutes County Health Department in each program. On a typical day 125 or more calls are received from the public wanting information on health related matters. Callers seek information ranging from primary care and to mold control, to animal bites, and how to access the Oregon Health Plan. Clinicians and front office staff frequently serve as broker of information to clients and make referrals for additional health and social services.

The Deschutes County Public Health Advisory Board has taken a keen interest in health promotion and health education and is working closely with the Central Oregon Health Council on a health promotion initiative related to reducing the impact of obesity and diabetes. The Director personally handles most calls related to Environmental Toxicology other than calls related to childhood poisoning which are handled by MCH staff.

We have added FTE to our health promotion staff which created a Community Wellness Coordinator at 1.0 FTE. This position works closely with community partners, to develop and implement plans for expanded health promotion and community wellness activities based on community need, as well as the Public Health Advisory Board.

5. Environmental Health Services

Deschutes County is fortunate to have a staff of highly trained and dedicated licensed sanitarians who do an outstanding job of assuring for the safety of public food establishments, pools, spas, daycare facilities, drinking water systems and septic systems.

The Deschutes County Environmental Health (EH) program currently operates through the Community Development Department of the County and provides licensed facility and food safety inspection, on-site sewage disposal permitting, and public water system inspection and assurance work. The team is cross-trained in a number of aspects of Environmental Health services to take advantage of workflow often dependent upon the local winter climate. A close working relationship exists between the EH program staff and the Communicable Disease control team within the Health Department.

2006-07 brought a continuation in the number of Environmental Health issues addressed collaboratively between these two Departments. The Public Health Director has an oversight role in all critical CD and EH case situations that have human health impacts and will secure a more formal relationship when Licensed Facility and Drinking water work transfers into the Public Health Department in July of 2007. Currently a joint governance model for Environmental Health services and supervision exists between the Public Health Director and the Director of Community Development. Going forward we plan on including a member of the Environmental Health Team at planning/strategy meetings in regards to disaster and public health preparedness planning.

Licensed Facilities – Food Inspection Protection Program

Deschutes County, once again, holds the distinction of having the most licensed facilities to inspect per-capita in Oregon. In 2007 the EH staff **inspected 1,850** food service establishments, temporary and mobile food units, commissaries, warehouses and bed and breakfast establishments. In addition, the Licensed Facility team **conducted a plan review on 85** new or remodeled restaurants and provided **1,325 food handler tests**. The team also converted from the State DHS database system to Verizon/Accuterm database which provides for “real time” data. The staff also taught 5 food handler classes across the communities we serve. Staff works in an “education” mode as much or more than an “overseer” mode when they conduct routine inspections, providing collegial relationships with the vendors.

Safe Drinking Water

The Environmental Health Division continues to provide professional technical and regulatory assistance to all **184 public water systems** in Deschutes County. The team conducted **30 comprehensive sanitary surveys** in 2007 and followed up on **10** deficient surveys. The team also investigated **31 water quality alerts** associated with bacteriological and/or chemical contamination and responded to and resolved **3 significant non-compliers** (systems not meeting EPA standards). The operators of the water systems follow the procedures for sampling and providing the population with safe drinking water. The County makes sure the sampling protocols are followed and follows up on samples which do not meet the Federal Safe Drinking Water Standards. The team is deserving of commendation for their continued efforts to reduce the number of systems on **the EPA Significant Non-Compliant list from 60 in 2000 to just 3 in 2007**. Security and Emergency response plans are reviewed.

Currently, the County is engaged in an action plan to preserve the quality of the groundwater – drinking water source – in southern Deschutes County. The plan addresses nitrate reducing technology associated with homeowner septic systems. A U.S. Geological Study recently revealed the high probability of increased nitrate contamination if a remediation strategy is not adopted and implemented. The Deschutes County Health Department worked with State staff to develop public messages on the Health effects of nitrate consumption associated with Drinking water.

In 2008 the Environmental Health Department is completing a project that will map all County drinking water sources. This will ensure that if a source is contaminated residents can be immediately notified and directed to the appropriate alternative water source.

On-Site Wastewater Treatment:

The Environmental Health Division assessed **315 sites** for feasibility for on-site wastewater treatment and dispersal systems and issued **1,772 permits and authorizations** for new and existing systems. The program also performed **1880 inspections** to ensure proper siting, installation or abandonment of on-site systems and permitted and inspected the replacement of **10** substandard trench systems, as well as helped facilitate the abandonment of **5** sewage dill holes.

Pool, Spa and Tourist Facilities:

The Environmental Health Division performed **350 pool and spa inspections in 2006** and an additional **50 inspections of tourist accommodations**. In addition, the team reviewed **23** pool/spa plans for new facilities in 2006.

Schools & Childcare Facilities:

The EH team conducted **102 National School Lunch Program Inspections** in 2007, serving over 19,500 students per day. Related to inspection of Day-Care facilities, the EH team **conducted 70 inspections of licensed child care facilities** giving the team a 100% inspection rate.

Adequacy of Other Key Services – Critical to Public Health

Community Advocacy and Multicultural Health

LHD has provided support to local the community coalitions addressing hunger, homelessness, methamphetamine abuse, child abuse, access to health care, childhood obesity and asthma. The Department is proud to support staff and information who need facility access to care for non-English speaking clients and to be a leader in the community for assisting other agencies to do the same.

(Note: Deschutes County Health Department hosts the Cascades East Learning Center interpreter students at our site to provide more clinical learning opportunities for the program.)

Breast and Cervical Cancer – Safetynet Services

Sadly, the Oregon Breast and Cervical Cancer Program has not done a good job of its recent transitions at the State or local level, and access to care for this critical service has been progressively and greatly reduced in the past 20 months. After several years of providing the administrative and case management components of the program the local Health Department was compelled to relinquish a regional based system with the promise of a new, more efficient State-wide system in July of 2006. Expectation of a State-wide system to manage eligibility, provider payment and client data management has not materialized. After 8 months of attempting to patchwork the various components to the program the Deschutes County Health Department realized the inability of sustaining this system.

We made a difficult administrative decision to phase out participation in this program and are no longer accepting patient referrals from across our Community. Prospective patients are now being referred back to the State hotline. Bend Memorial Clinic continues to accept patient referrals for screening and clinical follow-up. The Community Clinic of Bend has recently elected to curtail accepting patient referrals but will continue to screen and enroll eligible women from within their established patient clientele. The Deschutes County Health Department has prospective BCC clients scheduled for screening into June of 2007, but has ceased accepting more referrals. We truly hope the new State-wide system is fully operational by September of 2007, as currently anticipated.

Emergency Preparedness

Since the Fall of 2005 the Department has taken a keen focus on Health System readiness and capacity to respond to large scale health events such as what might be expected during a pandemic influenza event. This endeavor concerns preparedness across the entire community health system, not just the local Public Health Department... The Department was able to fund a part-time position focused in this arena. Dwindling public and private financial capacity to serve increasing health and social needs will necessitate community-wide efforts to build and sustain healthy livable communities.

Emergency Preparedness in Deschutes County has improved with the Bioterrorism Grant and restructuring of the Department focusing on a Communicable Disease Center. Program staff have developed smallpox plans, improved CD response times, developed a Pandemic Flu Plan, collaborated with community partners, and developed a new Bioterrorism response plan incorporated in the County Emergency Response Plan. DCHD continues to work with the County emergency

manager to plan County exercises. The Strategic National Stockpile plan was completed in 2005 and is exercised each year.

Department participated in a mass casualty drill in June of 2006. The team is currently working on the regional plan with the HRSA BT Coordinator and working with Cascade Health System and the community on preparedness. The program will continue to develop materials on mass casualty and improve surveillance with providers.

The 24/7 system through an answering service improved the capability of the staff to respond immediately to a Public Health issue. We also continue to meet with Jefferson and Crook County staff to improve coordination through the Region. The staff will be leading the effort to improve the capability of all Health Department staff to respond to an emergency through ICS/ NIMS training.

Laboratory Services

DCHD provides laboratory services in compliance with CLIA standards. The DCHD lab manager oversees the laboratory procedures and provides technical services to clinicians. DCHD has a contract with Central Oregon Pathology to provide those services not conducted at Oregon Public Health Labs or our local St. Charles laboratory. This arrangement provides for full service laboratory services for family planning and sexually transmitted disease services. Arrangements are made with other local full service medical labs to perform diagnostic lab work outside the scope of our internal labs. Local labs also report conditions reportable to the Communicable Disease team.

Nutrition

Screening, education, and assessment are provided extensively in MCH and WIC programs and are also offered to pregnant women in Prenatal Care Clinic. Targeted screening and assessment provided to adults in Family Planning and safety net primary care clinic. An acute focus on School Nutrition has been developing over the past two years and Bend, La Pine and Redmond Schools are well ahead of State mandates when it comes to the nature of foods served and sold on their campuses.

Older Adult Health – Flu, Pneumonia, Norovirus, Falls

Prevention messages are provided to seniors through the Immunization and Communicable Disease Program. Media events promoting adult immunizations are provided yearly, and the Immunization staff is working with private medical providers to improve the adult immunization rates in offices. The Health Department maintains a senior resource directory and information is given to clients regarding diabetes, chronic disease, breast and cervical cancer, and immunization clinics.

Injury related to Senior adult falls is an area needing more attention and community-wide collaboration. We will explore how to facilitate addressing this in 2007-08.

Primary Health Care Access for Low-Income Residents

As mentioned in a previous section of this Annual Plan, it is estimated some 25,000 plus Deschutes County residents, or approx. 18% of the population is without health insurance coverage. In addition, those with Fee-for-service Medicare and Oregon Health Plan coverage suffer from a private market health care community which has greatly limited or closed their practice to these individuals, citing low reimbursement rates. We estimate 35,000 – 40,000 residents suffer from an economic barrier to basic health services. Many of these are children, working adults and new Hispanic families. In 2002 there were approx. 3,000 adults, in addition to 300 pregnant women covered under the Oregon Health Plan. At the end of 2004 there were only 680 adults still covered under the plan, due to dramatic changes in eligibility.

Deschutes County Public Health has been at the forefront of addressing this inequity for the past 10 years. The HealthyStart Prenatal Program, a partnership between St. Charles Medical Center, East Cascades Women's Group and the County have provided full obstetrical and delivery care to all pregnant women with the inability to afford private marked health care. The FAN Wellness program, operated by the Deschutes County Health Department, provides a minimal level of safety net primary care services to school age children without any other access to basic care, but this program will be discontinued next school year due to school funding cuts.

A new Student Based Health Center (SBHC) opened in La Pine in late 2005, followed by a Federally Qualified Health Center (FQHC) in Bend, *The Community Clinic of Bend*, operative by the Ochoco Health System. The Department is working closely with and supports the efforts of Ochoco FQHC clinic in Prineville to establish this *Expansion-site Clinic*. In April of 2007 the County granted \$56,000 to the Ochoco Health System to add staffing capacity to help explore the feasibility of expanding services to the La Pine area. Recently a decision was made by the Ochoco Health System to forego expanding into La Pine at this time.

From 2002-2004 the Department operated a Community Care Clinic for medically indigent adults while working closely with other community partners to establish a Volunteer in Medicine Clinic (VIM). In the Spring of 2004 the Volunteers in Medicine Clinic officially opened and provided nearly 7,500 patient visits in 2006. In September of 2003, a private clinic in La Pine was designated as a Rural Health Care clinic.

Limited primary care still exists for both OHP and Medicare patients. Many local primary care physicians have severely limited their practice to these patient populations.

Indigent Care for Pregnant Women

Low income and uninsured women receive prenatal care and delivery services through the *HealthyStart Prenatal Program*. OHP eligibles are seen until enrollment and then transferred to private care. The program delivered 159 births in 2005, 182 in 2006, and 187 in 2007. The program is a close collaboration between the LHD and St. Charles Medical Center, and contracts with local OB practice, obstetrical and Nurse Midwifery services. The demographic profile of our clients has shifted towards Hispanic women, who do not have OHP coverage. We estimate there are, on average, 250+ pregnant women per year who fall between 100-185% of FPL. A loss of eligibility for OHP would simply overwhelm our local safety net program.

Central Oregon Health Collaborative – (Now named Health Matters)

This is one of Oregon's Community Based Action groups attempting to address system reform aimed at improving health and access to care. The Collaborative recently received its 501c3 status and may soon attempt to model a suite of services similar to CHOICE Health out of Olympia, Washington. Other interests of the collaborative involve employee health and worksite wellness as well as community development initiatives that enhance the opportunity for residents to exercise, walk, bike and socialize. Most recently the collaborative has begun an initiative looking at Medical Home placement for children with Special Health Care Needs. Alisha Hopper was appointed as the Executive Director.

WIC – Women Infants and Children

The WIC program offers nutrition counseling, referral services, breastfeeding education and food vouchers to women who are pregnant, post-partum and/or breastfeeding. The program also serves children from birth to five years old. The WIC Nutrition Education Plan for 2008-09 focuses on

obesity reduction, increasing physical activity, and increasing breastfeeding rates among clients (see **Appendix B**).

III. ACTION PLAN

Epidemiology and Control of Preventable Disease & Disorder

COMMUNICABLE DISEASE 2007-08 Plan

The Communicable Disease Program in Deschutes County continues to grow with increased numbers of disease cases, food-borne outbreaks, and requests for information from the community. The County population growth has increased from 115,367 in the year 2000 to over 152,000 in 2006. Chlamydia (CT) continues to be the highest reported disease in Deschutes County. CT cases increased to 395 in 2007. The cases have nearly doubled in four years, which creates an increased workload on staff for follow-up. Gonorrhea case rates are below the State average, but have increased over the past few years, primarily in middle-aged white men. The County has also had several syphilis cases over the last few years.

Deschutes County continues to have slightly higher than average rates of Giardiasis (compared with other Counties in Oregon), the number of Campylobacter continues to be our main waterborne disease, and rates are on the high end compared to other Oregon Counties. The number of food-borne illness outbreaks (Norwalk) has increased dramatically with the growth of the community, and retirement homes in the area. Deschutes County averages 25 cases of Hepatitis C a month (non-acute), and since it became reportable in 2005 we are continuing to see numbers rise.

After several years of no reported active tuberculosis disease, in the past three years we have seen a substantial increase in the number of suspect TB cases in our area. In 2006 we had 44 individuals on LTBI (latent tuberculosis infection) and two active TB cases to manage. The Communicable Disease (CD) team updated the West Nile Plan, implemented surveillance in 2003, which has continued to date, and is preparing for the Spring of 2007.

The program has completed the development of a Pandemic Flu plan, and is in the process of working with other employers and organizations to continue building an infrastructure that can address the threat of community-wide disease outbreaks. The program is participating in health system preparedness with Cascade Health System, has planned and practiced a number of table top exercises, participated in the Strategic National Exercise in 2005, as well as the State wide Pandemic Influenza drill in November of 2006. Future trends include increased surveillance and awareness of potential Communicable Disease threats such as Pandemic Influenza, West Nile Virus, Bioterrorist agents, etc.

The program has completed the development of a Pandemic Flu plan, and is in the process of working with other employers and organizations to continue building an infrastructure that can address the threat of community-wide disease outbreaks. The program is participating in health system preparedness with Cascade Health System, has planned and practiced a number of table top exercises, participates in the Strategic National Exercises, as well as the State wide Pandemic

Influenza drills. Future trends include increased surveillance and awareness of potential communicable disease threats such as Pandemic Influenza, West Nile Virus, Bioterrorist agents, etc.

EMERGENCY PREPAREDNESS

Emergency Preparedness in Deschutes County has improved with Preparedness Grant dollars and restructuring of the Department focusing more on how we will pull together as a team to address community disasters. Program staff has developed specific plans for a variety of potential threats to our County, as well as creating and participating in exercises to practice their functionality.

In 2006 the Department was a key player and planner of the Oregon State wide Pandemic Influenza exercise. It included a variety of partners from around the County, and was a great success in identifying response strengths and weakness within our Department and community.

All hazard response plans are incorporated in the County Emergency Response Plan. DCHD continues to work with the County Emergency Manager to plan County exercises. The Strategic National Stockpile plan was completed in 2005, exercised, and revised again in 2007. The team is currently working on the regional plan with the HRSA Coordinator, with Cascade Health System and the community on exercising plans, working together as a community to clarify roles, pool resources and staff. The program will continue to develop materials on mass casualty, participate in County and State exercises and improve surveillance with providers.

The 24/7 system works via an answering service, where a nurse can be reach at all times to receive disease and disaster reports of Public Health significance. On average for 2006 we received an average of 3 after hour calls per month from the public. We also continue to meet with Jefferson and Crook County staff to improve coordination throughout the Region. The staff will be leading the effort to improve the capability of all Health Department staff to respond to an emergency through ICS/ NIMS training.

FOOD-BORNE ILLNESS REPORTS

Food-borne illness in Deschutes County remained similar to previous years with four E-Coli 0157 reports and twelve Salmonella reports. At the end of 2005 there was a very large E-Coli 0157 outbreak, in which we had an opportunity to use the incident command system, as well as the production of a food-borne outbreak manual for future events.

Public Health and Environmental Health continue to work together to address outbreaks, health education in the community, and sharing workload to appropriately address community concerns. There has been an increase in the number of Norwalk-like illnesses with multiple nursing home and school outbreaks reported in both 2005 and 2006. Each year, as reports increase and staff numbers remain the same it becomes more and more difficult to thoroughly investigate each Norovirus outbreak.

IMMUNIZATIONS

The Immunization Program has worked hard to improve rates for two-year olds. In 1999, the County was ranked thirty-fifth and steadily has moved up the scale State wide. The extensive work with coalitions, community education, and providers has made a difference in outcomes. We are also seeing many more infants being vaccinated for Hep B at birth starting in 2006.

The Shots for Tots Program will continue with the sponsorship through the High Desert Rotary Club. The club has chosen the Shots for Tots Program as their project with funding each year through the Rotary Duck Race and numerous fundraising projects. Issues in Deschutes County include

prevention of Pertussis with an increased number of parents choosing not to immunize, Hepatitis B vaccinations implemented in the hospital, and the growing population of young children with no health care. The Immunization Coordinator will be continuing to work on a State wide project to improve the status of the 4th DTap, as well as improve our birth to two-year old immunization rates for 2008. The last two years have been challenging for the program with staff turnover and inability to do much outreach in the community.

TOBACCO PREVENTION PROGRAM

Tobacco Use: Deschutes County is above State average rates for smokeless tobacco use in both adults as well as our 8th and 11th graders. In 2006 we also saw a dramatic increase among our youth with cigarette smoking, which spiked up to 27.8% of our 11th graders reportedly smoking. Our tobacco Prevention Coordinator and Tobacco Free Alliance is focusing on key areas that involve access to smoking cessation resources, reaching youth, promoting tobacco prevention resources in minority populations, and addressing second hand smoke exposure. Our County has had success in preventing pregnant women from using tobacco, which is reflected in the 11.1% use, lower than both the State average as well as the Healthy People 2010 objective.

CONTROL OF REPORTABLE COMMUNICABLE DISEASE

CURRENT CONDITION OR PROBLEM

A constant in the realm of Public Health is Communicable Diseases have long been known to be the primary cause of morbidity and mortality in man. Over the past hundred years the incidence and prevalence of Communicable Disease has diminished. These declining rates were due to improved systems of sanitation and hygiene practices as well as the development of vaccines help prevent the spread of disease. However, in recent years morbidity and mortality rates are climbing from new identified diseases and resurgent of old ones. According to the Oregon Health Services the five most prevalent infectious diseases in Deschutes County for 2006 were:

- Chlamydia
- Hepatitis C
- Campylobacter
- Giardiasis
- Salmonellosis

The sexually transmitted disease, Chlamydia continues to be the highest reported disease in Deschutes County. The cases have doubled in the last 4 years which has increased workload for our staff a great deal. Gonorrhea and Syphilis have also established a presence in the last 5 years, and continue to increase with the population growth.

Deschutes County continues to have high number of waterborne disease cases and increased numbers of Norwalk-like Viruses in congregated living settings.

Tuberculosis. After several years of no reported active tuberculosis disease, the past two years included several new cases of both active TB, and inactive infections (LTBI). Also, due to the large geographical area it has been difficult for nurses to travel daily to do directly observed therapy. The travel and time allotted has put a strain on other program priorities.

GOAL

To improve/ maintain the health status of the citizens of Deschutes County by preventing/ reducing the incidence of Communicable Disease through outreach education, epidemiological investigation and surveillance activities.

ACTIVITIES:

Target Population	Who	What	Timeline
Deschutes County Residents	CD Coordinator	(Objective 1) Mechanism in place to receive, evaluate, respond to urgent disease reports 24 hours a day, 7 days a week. Provide epidemiological investigations on 100% of reportable diseases with 24 hours.	ongoing
Deschutes County Residents	CD Team	(Objective #2) <ul style="list-style-type: none"> • Case investigations are complete (>100%). • 100% of reported cases are reported to DHS by end of the calendar week of the completion of the investigation. • Information and recommendations on disease prevention are proved to 100% of exposed contacts locally. • All demographics are completed on the case reports. • CD investigations are to begin within one working day. • Update CD database as needed. 	ongoing
Medical Providers	CD Coordinator Outreach Worker	(Objective #3) Increase the number of medical providers reporting Communicable Disease appropriately through outreach and education. <ul style="list-style-type: none"> • An emergency system for communication of CD alert information will be maintained. 	ongoing
Medical Providers	CD Coordinator	(Objective #4) A more consistent feedback system, regarding the outcome of the investigation will be provided to the health care provider.	11/1/07
Veterinarians	CD Coordinator	(Objective #5) Develop an improved zoonotic disease reporting system. Create an e-mail alert system for veterinarians.	12/1/09
Deschutes County Residents	CD Team	(Objective #6) Develop a Hepatitis C Plan that will address the increase in disease reports and community follow-up strategy within staffing constraints.	01/01/2009
Deschutes County	CD Team	(Objective #7)	Completed

Staff		Provide blood-borne pathogen training to staff each year.	
Deschutes County Residents	CD Team	(Objective #9) Update the Pandemic Influenza Plan and continue to prepare the community.	12/01/07

EVALUATION:

- Objective 1: 24/7 System in place with positive test results.
- Objective 2: Completed reports sent to State – monthly evaluation.
- Objective 3: Improved reporting and communication with medical community.
- Objective 4: Development of a system for provider feedback and implementation.
- Objective 5: Development of a system for Veterinarian reporting and implementation.
- Objective 6: Completion of the Hepatitis C Plan.
- Objective 7: Documented training.
- Objective 8: Updating of Pandemic Influenza Planning and develop Health System Preparedness Plan.

EMERGENCY PREPAREDNESS

CURRENT CONDITION OR PROBLEM

Emergency Preparedness in Deschutes County has improved over the last 5 years with grant support and staff who are dedicated to helping the Department and community prepare for hazards that could overwhelm the County. Program staff have developed numerous plans, improved CD response times, collaborated with community partners, developed a basic disaster response plan, and continue to work with the County emergency manager to implement all the information into the County response plan. Needs include completion of materials on mass casualty, increased activity on the planning group, development of a health focused planning group.

GOAL

To improve the response to Communicable Disease and Public Health Emergencies throughout Deschutes County.

ACTIVITIES

Target Population	Who	What	Timeline
Deschutes County Residents	CD Program Manager Preparedness Coordinator	(Objective # 1) Participate with St. Charles Medical Center and Emergency Management on an area preparedness planning group. -to complete State requirements on drill development and practice, engaging community partners in the process. - Pandemic Planning ongoing.	ongoing
Deschutes County Residents	CD Team	(Objective # 2) All Hazards Plans are integrated into the Local Emergency Operations Plan.	ongoing
County Partners	CD Team	(Objective # 3) We are still waiting for approval of mutual Aid agreements for regional area. Hope to complete this year.	12/01/07
Deschutes County	CD Manager	(Objective # 4)	ongoing

Residents		24/7 contact information as been provided to DHS, Health Services, and other public safety agencies.	
Mass Immunization Population	Immunization Coordinator CD Coordinator	(Objective # 5) Update and review NPS Plan. (CD)	12/01/07
Deschutes County Residents	Preparedness Coordinator	(Objective # 6) Complete/update development of all plans: <ul style="list-style-type: none"> • Mass Prophylaxis • Smallpox Response • Pandemic Flu • Lab and provider reporting • Mass Casualty • Mechanisms for receiving and responding to CD reports • Identification and planning for meeting the needs of special populations 	12/31/07
Deschutes County Residents	CD Team	(Objective # 7) Health risk information is communicated and disseminated through, but not limited to the following measures: <ul style="list-style-type: none"> • Individual chosen to carry primary responsibility for coordinating aspects of public information communication has been designated. • The LHD communication officer actively participates in State wide planning and coordination of Public Health messages. • The LHD communication officer is educated in the concept if ICS communication structure. • Local staff has participated in training for risk communication and how to use those techniques effectively. 	12/31/07
Veterinarians Animal Population	CD Coordinator	(Objective # 8) Improve the Animal Surveillance system in Deschutes County through the Broadcast Fax system.	11/01/07
Department Staff	Preparedness Coordinator	(Objective # 9) Training plan for all staff to be ICS and NIMS compliant.	12/31/07

EVALUATION:

- Objective 1: On-going Disaster Planning Group
- Objective 2: Integration of all plans
- Objective 3: Mutual Aid agreements in place
- Objective 4: 24/7 communication intact
- Objective 5: Completed NPS Plan
- Objective 6: Plans completed
- Objective 7: Risk Communication training documented and plan completed

Objective 8: Improved Animal Surveillance System
 Objective 9: Staff trained in ICS and NIMS

HIV

CURRENT CONDITION OR PROBLEM

The number of HIV positive individuals continues to grow in Deschutes County with the increase in population. The incidence and prevalence of reported AIDS cases have been low, with no unusual aspect to the demographics. During the first year of the new HIV testing statistics, there were 16 reported cases of HIV in Deschutes County with 6 cases of AIDS. HIV individuals in Deschutes County still find difficulty living in a community with fears around HIV. There are currently 55 HIV positive clients enrolled in the HIV Case Management Program with the Health Department. It is anticipated that HIV caseloads will grow steadily over the next few years as more people move to the area.

Future needs include concerns about their need for medical care and medication with the loss of the Oregon Health Plan Programs. The program has seen an increase in positive women and new individuals moving to the area from out of State. Future trends and concerns also include the rising IDU use in the County and Hepatitis C cases which have a high co-morbidity rate with HIV. There is a new State law supporting the testing of pregnant women for HIV testing. As a Health Department and prevention team here in Deschutes County we are focusing our outreach on high-risk groups which include those who use injection drugs and men who have sex with men.

GOAL

To improve/ maintain the health status of the citizens of Deschutes County by preventing/ reducing the incidence of Communicable Disease through outreach education, counseling, and testing for HIV.

ACTIVITIES

Target Population	Who	What	Timeline
HIV High Risk Population HIV Women HIV MSM	HIV Program staff	(Objective 1) Organize and reassess the acuity levels of the client load in HIV Case Management	12/31/07
HIV High Risk Population	HIV Program staff	(Objective 2) Increase the percentage of high-risk Deschutes County residents counseling and tested for HIV by 10% for the 2007-2008 fiscal year.	06/30/08
Women and Children at risk for HIV	HIV Program staff	(Objective 3) Improve the provider HIV testing of pregnant women through outreach and education. (New State law addressed this in 2005)	6/30/08
Deschutes County Residents	Program Manager HIV Staff	(Objective 4) Update and improve Prevention Plan based on new CDC Guidelines.	Complete
High Risk	HIV Staff	(Objective 5)	

Population MSM, IDU	STD Clinician FP/STD Coordinator	Increase HIV testing numbers in the community using the new HIV Rapid Test. (Implemented)	6/30/08
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EVALUATION:

- Objective 1: Organize and reassess participants in the HIV Case Management Program.
- Objective 2: Increased number of HIV Tests performed for fiscal 07-08.
- Objective 3: Survey providers on HIV Testing activity.
- Objective 4: Evaluate each HIV Prevention activity and report quarterly to the HIV Program.
- Objective 5: Measure the number of new HIV tests completed.

**HARM-REDUCTION (HEPATITIS B AND C AND HIV)
GOALS AND ACTIVITIES**

Objective	List Resources	Activities	Expected effects/Outputs	Context
Reduce Hepatitis and HIV infection in people who use injection drugs and their networks.	Outreach staff member, Health Department buildings, and drop boxes around the County.	Facilitating needle exchange, providing boxes for people to drop dirty needles in after hours throughout County. Promotion through word of mouth, pamphlets, cards, websites. Educational presentations given to local drug and alcohol treatment groups regarding HIV and Hepatitis transmission and prevention in an effort to increase awareness.	To prevent new HIV and Hepatitis infections, decrease client needle sharing, decrease reports of needles found in the community.	Conservative community that is just now starting to adopt harm reduction principles for the safety of the community at large. We are now seeing more people use the exchange and drop boxes than the previous year.
Increase testing among people who use injection drugs (IDU)	OHROCS program	Work with other community partners to build OHROCS program, promote testing with IDU clients, STD clinic clients, jail counseling and testing, jail risk reduction counseling, promote needle exchange services, and increase needle exchange sites.	Promote HIV and Hep B & C testing among HD locations, develop and distribute informational and referral materials. -Outreach materials distributed to 15 IDU establishments: jail, parole and probation, parks, Laundromats, food banks, shelters, drug treatment centers, addiction	Location of Health Department may be a barrier- not in a central location and thus transportation is a hindrance.

			recovery support groups, bars, hotels. *Target number of people who use injection drugs to be reached with HIV testing: 25.	
Reduce Hepatitis and HIV infection through education and peer support of practicing safer sex in the MSM population	Outreach staff member, advertising resources, word of mouth networking internet resources, local PRIDE event, Drag Show, LGTBQ Fashion Show, Rainbow Alliance membership, State assistance.	Promotional material, ads in local newspaper to increase interview opportunities on how to best reach the population and create buy-in from MSM population. Outreach through adult stores.	-To have a larger network of contact in the MSM population who are passionate about partnering to reduce infection and spreading the word. -To increase our knowledge about our local MSM population, how best to reach, network with, and interventions that will be the most successful. -Outreach materials distributed to 5 MSM establishments: adult stores, parks, gyms. -Outreach at 2 events organized by Human Dignity Coalition (PRIDE, Drag Show).	Conservative community. Very difficult to break into the MSM network – quite underground. At this point we are focusing most of our efforts on networking to increase our understanding of the attitudes, beliefs, and behaviors of local MSM. Barriers include closeted, non-gay identifying, and down-low MSM. Building relationships with MSM is also an on-going project of the outreach worker. Peer supported interventions have not been received very well due to the community.
Increase HIV testing among MSM population	Outreach staff member, possible MSM peer volunteer	-Staffing and different offsite locations to look at testing opportunities, promotional material, networks already created to spread word and encouragement of testing. - Male Only Clinic will be held twice a month. This clinic	Increase testing among MSM. *Target number MSM to reach with HIV testing: 25	Few MSM utilize the Health Department for HIV counseling and testing services.

		began 2/28/08 in efforts to increase testing among men, especially MSM.		
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TUBERCULOSIS

CURRENT CONDITION OR PROBLEM

Deschutes County has seen an increase in the amount of active TB cases, as well as LTBI cases. The result of new cases has increased the need for additional staff to assist in the Communicable Disease Program. In 2002 there were 32 clients receiving INH, 2005 the number jumped into the 60s and in 2006 down into the 40s (partly due to staff ability to do more outreach to treat). There has been a trend of Hispanic clients receiving LTBI in the past three years. The program hopes to work more with the homeless population, as well as other high-risk groups to treat inactive infections before they become contagious.

GOAL

To provide comprehensive services to the community for the prevention and treatment of tuberculosis, while focusing on TB awareness and education throughout Deschutes County.

ACTIVITIES:

Target Population	Who	What	Timeline
Deschutes County Residents	CD Coordinator	(Objective # 1) Increase the # of PPD provided through DCHD to high risk populations, and decreased to low risk populations	6/30/2008
Deschutes County Residents	CD Coordinator	(Objective # 2) HIV Testing will be offered to all cases and suspected cases of Tuberculosis	ongoing
Deschutes County Residents receiving LBTI through DCHD.	CD Coordinator	(Objective # 3) Improve the number of clients completing LTBI from 60% to 75%.	6/30/08
Medical Providers	CD Coordinator	(Objective # 4) Increase awareness to medical providers for active TB cases.	ongoing
Shelter residents	CD Coordinator Program Mgr.	(Objective # 5) Explore the Implementation of a screening program for shelter residents.	12/31/07
Deschutes County Residents	CD Coordinator and Team	(Objective # 6) Update policies, forms, and protocols annually. (Completed)	on-going
Deschutes County Employees	Manager and CD Coordinator	(Objective # 7) Update employee respiratory protection and screening program annually and provide fit testing for staff.	ongoing

EVALUATION:

- Objective 1: Target PPD tests provided through DCHD
- Objective 2: Documented HIV Testing
- Objective 3: Statistics from Oregon Health Services
- Objective 4: Number of presentations and information packets to providers
- Objective 5: Number of residents from shelter receiving screening
- Objective 6: Updated protocols and policies – documentation
- Objective 7: Updated policy and documented fit testing

IMMUNIZATIONS

CURRENT CONDITION OR PROBLEM

The Immunization Program needs continue to grow with the increasing population in Deschutes County. The lack of providers who will see children with Oregon Health Plan is a concern and the poverty level has increased with the increased unemployment. Shots for Tots continues to fill a gap, but the gap is growing. The Immunization Program has worked hard to improve rates for two-year olds, though there are still improvements to be made. The extensive work with coalitions, community education, and providers has made a difference in outcomes. Issues in Deschutes County also include prevention of Pertussis with an increased number of parents choosing not to immunize, and the growing population of young children with no health care. We are seeing more physicians vaccinating infants at birth for Hepatitis B, which is an improvement from previous years.

GOAL

To improve the mortality and morbidity rates of Deschutes County citizens by reducing vaccine preventable diseases.

<p>Continue strategies from 2007 and</p> <p>Increase the up-to-date immunization rates of children under 24 mos old by 6% over the next 3 yrs.</p>	<p>Compare stats with 2006 AFIX report</p> <p>Provide immunization information to expecting and new mothers.</p> <p>A. Prenatal classes B. Handouts at OB clinics. C. Handouts at birthing centers</p> <p>Promote co-operative working climate with local clinics.</p> <p>A. Hold annual info Mtgs/trainings.</p>	<p>Increase up-to-date rates by 2% over last year</p> <p>Activities were implemented as planned.</p> <p>Missed opportunity rate in decreased within HD.</p>	<p>To be completed for the FY 2009 report</p>	<p>To be completed for the FY 2009 report</p>
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Local Health Department: Deschutes County
Plan A – Continuous Quality Improvement: Increase Up to Date rates for two-year olds. Fiscal Years 2007-2010

Year 3: July 2009– June 2010				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
Continue strategies from 2008 and Increase the up-to-date immunization rates of children under 24 mos old by 6% over the next 3 yrs.	Compare stats with 2006 AFIX report Provide immunization information to expecting and new mothers. D. Prenatal classes. E. Handouts at OB clinics. F. Handouts at birthing centers. G. Referrals from hospital.	Increase up-to-date rates by 2% over previous year Activities were implemented as planned.	To be completed for the FY 2010 report	To be completed for the FY 2010 report

Local Health Department: Deschutes County
Plan B - Chosen Focus Area: Increase Participation and quality of data to Alert
Fiscal Years 2007-2010

Year 1: July 2007– June 2008				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
Increase the number of ALERT	Use 2006 ALERT participation data as baseline.	# of participants in ALERT increased (Contact is	To be completed for the FY 2008 report	To be completed for the FY 2008 report

¹ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

² **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

¹ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

² **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

<p>participants in Deschutes County.</p> <p>Increase amount of data submitted and improve quality of submissions</p>	<p>Review current participation & identify clinics needing improving.</p> <p>Recruit any site not reporting (talk encourage electronic reporting).</p> <p>Arrange for ALERT users class & invite players to attend. Use Alert video, Invite Health Educator to participate.</p>	<p>Marybeth Kurilo 971-673-0294)</p> <p>ALERT training classes held.</p> <p>Visits to sites needing in house training.</p> <p>Info submitted to ALERT within 30 days of immunization</p>		
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Local Health Department: Deschutes County
Plan B - Chosen Focus Area: Increase Participation and quality of data to Alert
Fiscal Years 2007-2010

Year 2: July 2008– June 2009				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
Continue with previous year objectives. Increase the number of ALERT participants in Deschutes County. Increase amount of data submitted and improve quality of submissions	Same plus: Review participation; determine number of sites submitting to ALERT. Review numbers submitted and have area Health Educator compare with vaccine ordering reports. Offer assistance to those sites needing help.	# of participants in ALERT increased over last year Quality of data submitted improved Information submitted within 15 days of immunization. Visit 2 clinics to offer technical and/or educational assistance.	To be completed for the FY 2009 report	To be completed for the FY 2009 report

¹ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

² **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

Local Health Department: Deschutes County
Plan B - Chosen Focus Area: Increase Participation and quality of data to Alert
Fiscal Years 2007-2010

Year 3: July 2009– June 2010				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
<p>Continue with previous year objectives...</p> <p>Increase the number of ALERT participants in Deschutes County.</p> <p>Increase amount of data submitted and improve quality of submissions</p>	<p>Same plus:</p> <p>Review ALERT participation reports and timeliness of reports (private practice clinics)</p> <p>Offer assistance classes or visit where needed. Sites delaying submission advised to do report more often.</p> <p>Promote co-operative working climate with local clinics. A. Hold annual info Mtgs/trainings</p> <p>Recruit for local clinic representation on the DCIC (Deschutes County Immunization Coalition).</p>	<p>Same plus:</p> <p>ALERT participation reports have been reviewed.</p> <p>ALERT training classes and visits made.</p> <p>Immunization rates should increase.</p>	<p>To be completed for the FY 2010 report</p>	<p>To be completed for the FY 2010 report</p>

¹ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

**Plan B - Chosen Focus Area: Maintain and Enhance the DCIC – Deschutes
County Immunization Coalition
Fiscal Years 2007-2010**

Year 1: July 2007– June 2008				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
Continue with previous year objectives... Maintain and enhance the DCIC- Deschutes County Immunization Coalition	Using 2006 make-up of DCIC Maintain the current membership A. Add community representation B. Involve child care providers C. Recruit school nurses D. Recruit special project reps (WIC, FAN) E. Do questionnaire on group's main goals.	Membership increased Increased diversity of membership is evident Strategic plans formulated and presented	To be completed for the FY 2008 report	To be completed for the FY 2008 report

¹ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

² **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

**Plan B - Chosen Focus Area: Maintain and Enhance the DCIC – Deschutes
County Immunization Coalition
Fiscal Years 2007-2010**

Year 2: July 2008– June 2009				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
Continue with previous year objectives... Maintain and enhance the DCIC- Deschutes County Immunization Coalition	Same plus: Review make up of coalition for possibly needed more recruitment Explore development of questionnaire for community to help define needs and gaps, and where the coalition. Provide recognition of members at annual public/private Immunization meetings	Membership maintained or enhanced with new members Members recognized at County level. Strategic plan approved	To be completed for the FY 2009 report	To be completed for the FY 2009 report

¹ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

² **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

**Local Health Department: Deschutes County
 Plan B - Chosen Focus Area: Maintain and Enhance the DCIC – Deschutes
 County Immunization Coalition
 Fiscal Years 2007-2010**

Year 3: July 2009– June 2010				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
Continue with previous year objectives... Maintain and enhance the DCIC- Deschutes County Immunization Coalition	Same plus: Review strategic plan and update as necessary for 2011-2013	Membership maintained or enhanced Member recognition achieved Review of strategic plan completed Draft of strategic plan accomplished for years 2011-2013	To be completed for the FY 2010 report	To be completed for the FY 2010 report

¹ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

² **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

**Plan B - Continuous Quality Improvement – Decrease the Late Start Rates in DC.
Fiscal Years 2007-2010**

Year 1: July 2007– June 2008				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results³	Progress Notes⁴
<p>Continue with previous year objective.</p> <p>Decrease number of late starts in DC by 3% over the next three years</p>	<p>Use 2006 Afix data as the basis of comparison for projected change (15% total 2006)</p> <p>Provide immunization information to expecting and new mothers</p> <ul style="list-style-type: none"> A. Prenatal classes B. Handouts at birthing centers <p>Provide Immunization information tapes to Hospital, birthing centers.</p> <p>Present this as a topic for discussion meeting with local clinic staff.</p>	<p>Decrease the late start date rate by 1% the first year.</p>	<p>To be completed for the FY 2008 report</p>	<p>To be completed for the FY 2008 report</p>

³ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

⁴ **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

**Plan B - Continuous Quality Improvement – Decrease the Late Start Rates in DC.
Fiscal Years 2007-2010**

Year 2: July 2008– June 2009				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results⁵	Progress Notes⁶
Continue with previous year objectives... Decrease number of late starts in DC by 3% over the next three years	Same plus: Discuss changes in rates at annual meetings with local clinics, Solicit ideas from them.	Decrease the late start date rate by 1% compared to last years rates	To be completed for the FY 2009 report	To be completed for the FY 2009 report

**Plan B - Continuous Quality Improvement – Decrease the Late Start Rates in DC.
Fiscal Years 2007-2010**

Year 3: July 2009– June 2010				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results⁷	Progress Notes⁸
Continue with previous year objectives... Decrease number of late starts in DC by 3% over the next three years	Same plus: Provide QI training for local clinics	Decrease the late start date rate by 1% compared to last years rates	To be completed for the FY 2010 report	To be completed for the FY 2010 report

5 Outcome Measure(s) Results – please report on the specific Outcome Measure(s) in this table.

6 Progress Notes – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

7 Outcome Measure(s) Results – please report on the specific Outcome Measure(s) in this table.

8 Progress Notes – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

WEST NILE VIRUS

CURRENT CONDITION OR PROBLEM

The Deschutes River Basin is home to the *Culex tarsalis*, *Culex pipiens*, and *Aedes vexans* mosquito. These mosquitoes all have the potential to carry West Nile Virus (WNV), and this will pose a threat for animals and humans in Deschutes County. The current problem includes lack of information to the general public and lack of a County-wide vector control district.

GOAL

Decrease the morbidity and mortality of West Nile Virus through the development of an updated West Nile Virus response plan.

ACTIVITIES

Target Population	Who	What	Timeline
Deschutes County Residents	Four Rivers Vector Control	(Objective #1) Continue surveillance activities for the presence of specific mosquitoes throughout Deschutes County.	Continue through Summer 08
Deschutes County Residents	Four Rivers Vector Control	(Objective #2) Maintain Vector control activities already in place.	ongoing
Deschutes County Residents	CD Coordinator and Environment Health Staff	(Objective #3) Solicit dead bird submissions for testing from the public and appropriate local agencies.	ongoing
Deschutes County Residents	CD Team	(Objective #4) Provide public information on personnel protective measures. Send updated plan to officials. (Completed for 06)	Spring Summer 2008
Deschutes County Residents	CD Coordinator	(Objective #5) Continue public hotline for Deschutes County residents on the issues relating to West Nile Virus.	Spring 08

EVALUATION:

- Objective 1: Surveillance activities ongoing through Spring and Summer
- Objective 2: Continue current vector control activities through contract with Four Rivers Vector Control
- Objective 3: Dead bird submission information to the public and system in place
- Objective 4: Collection of materials and articles to the general public
- Objective 5: Completion of community forums and ongoing update of West Nile Response Plan.

ADDITIONAL REQUESTS: No Revision to the Alert Plan.

***Parent and Child Health Services
Including Family Planning – ORS 435.205***

- A) ***Immunization***
(See Section Above Under Preventable Disease)

- B) ***WIC***
(WIC - See Appendix B)

- C) ***Family Planning***

**FAMILY PLANNING PROGRAM ANNUAL PLAN FOR
COUNTY PUBLIC HEALTH DEPARTMENT
FY 2008-09
July 1, 2008 to June 30, 2009**

Agency: Deschutes County Health Department
Contact: Kathleen Christensen/ 541-322-7407

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
FPEP qualification and enrollment changes along with the increase in clients who are seen at no charge or partial fee threatens the ability of this agency to maintain our current level of service. 42.4% of our clients are supported by Title X compared to the state average of 25.4%. Title X funds are only 12% of our budget.	1) Implement a new income screening process with the front office staff.	<ul style="list-style-type: none"> ➤ Train the front office staff to gently walk through the income screening portion of the intake form with the client to get a more accurate income. ➤ Use the income the client gave to other internal programs as a guide when completing income screening. 	<ul style="list-style-type: none"> ➤ Ahlers data and fiscal reports.
	2) Increase knowledge and understanding of the FPEP program within our staff with	<ul style="list-style-type: none"> ➤ Have all FP staff attend the FPEP Orientation and the Program Integrity Plan trainings by 	<ul style="list-style-type: none"> ➤ Training logs are completed.

	the end goal of increasing FPEP enrollment.	December 08. ➤ Provide incentives for clients to bring in paperwork.	
	3) Explore bringing the BCC Program back to Deschutes County Health Department. Within the past year we estimate that 100-150 of our no charge clients may have qualified for BCC.	➤ Meet with the state program to discuss if the revamped program would be feasible at Deschutes County Health Dept.	➤ Program is either implemented or not.
The front office reception area at the Main Office and Redmond Office are not very confidential for clients. This is uncomfortable for clients in general and makes it hard to obtain information pertinent to the check-in and billing process.	1) Work to create a more confidential reception area for both clinic offices in Bend and Redmond.	➤ Meet with Building Services to discuss possible structural modifications. ➤ Rearrange furniture and seating.	➤ Staff feedback ➤ Client feedback
There is a lack of community awareness about Deschutes County Family Planning Services.	1) Increase community awareness through advertising and community outreach.	➤ Work with Ana Johnson the county Public Communications Coordinator to establish an advertising plan. ➤ Increase the number of reproductive health classroom presentations at the local high schools and college by 25% over last year.	➤ Alhers data and fiscal reports. ➤ Community Outreach Log.

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
Unable to offer Implanon due to untrained staff.	1) Will have one NP trained and ready to offer Implanon insertion and removal by September 08.	<ul style="list-style-type: none"> ➤ Identify Implanon trainings and resources needed for clinic. ➤ Support NP/NP's to attend Implanon training. ➤ Offer Implanon as a birth control option. 	<ul style="list-style-type: none"> ➤ Implanon training completed. ➤ Record # of Implanon insertions.
With an increase in birth control prices and more high cost birth control methods being made available it is hard to keep the medication budget at a manageable level.	2) Continue to provide a broad range of birth control methods while being thoughtful in how medications are dispensed.	<ul style="list-style-type: none"> ➤ If the client chooses oral contraceptives as their method they will be started on low cost pills first. If high costs pills are used charting must support the reason for starting them on a higher cost pill. ➤ Assure method is appropriate for the client before giving large quantities. ➤ Continue to use the Arch Foundation for Mirena IUS's when possible. 	<ul style="list-style-type: none"> ➤ Financial Reports

Progress on Goals / Activities for FY 08
(Currently in Progress)

Goal / Objective	Progress on Activities
<p>Goal 1, Objective 1</p> <p>Provide culturally competent care for undocumented Hispanic women while preserving program resources.</p>	<p>At Deschutes County we do provide high quality culturally competent care for our non-FPEP qualifying Hispanic women. Several of our FP clinic staff speak Spanish, our Clinical Assistant is bi-lingual and most of the front office staff are bi-lingual.</p> <p>We have established several clinic times within each week that are designated Hispanic Clinics to assure an interpreter is available and the clients can be seen in a timely manner. We are referring clients who do not need contraceptive services and who would be better</p>

	served through the BCC program to the local provides who provide access to that program.
<p>Goal 1, Objective 2</p> <p>Strengthen program priority to focus on adolescent clients.</p>	The program has increased priority to focus on adolescent clients. We opened The Downtown Health Center for young adults 25 and under in a central location that is more convenient. We have educated the front office staff to prioritize adolescent services and try to fit them into the clinic that day by calling a back-up staff person or referring them to The Downtown Health Center when open. Although we prioritize services for adolescents a number of these clients do not have access to their birth certificate. This has been a problem in qualifying them for FPEP and continues to impact program reimbursement.
<p>Goal 1, Objective 3</p> <p>Continue to increase the number of F-PEP clients seen and maintain resources to sustain the Family Planning Program for individuals and the community.</p> <p>Goal 1, Objective 4</p> <p>Maintain a competent workforce for the Family Planning Program in order to continue to provide quality care.</p>	<p>There has been a high rate of staff turn-over within the front office in the past year. We are working very hard to increase staff retention through team work and job satisfaction. We now have a full staff that is getting more comfortable with their roles and responsibilities. The new front office supervisor has worked with the staff on efficiencies and program understanding. Due to this we are starting to see more consistency in the education and message that the staff are giving to the clients. We have developed some tools to help the clients understand what the FPEP program is and how it impacts our clinic as well as how it serves them. We are starting to see a decrease in the number of clients who need to have their citizenship verified.</p> <p>The county is reviewing positions and salaries.</p> <p>We continue to work on getting the clients to bring paperwork and information needed to their appointments- it is a challenge.</p>
<p>Goal 1, Objective 4</p> <p>Strengthen program priority to focus on adolescent clients.</p>	Although the Family Planning Program lost part of an FTE last budget year we combined several positions to create a full time position rather than several part time positions that are harder to fill. We are now fully staffed for the first time in 2-3 years. We have a <u>great</u> clinic team and barring any unforeseen happenings we should have the same staff for the next 5 years.
<p>Goal 1, Objective 5</p> <p>Increase the percentage of teen clients seen by 10%.</p>	We have seen a slight increase in the number of teen clients we are serving. There is a Planned Parenthood in Bend that does a lot of advertising to the younger population and a number of teens are served at that location.
<p>Goal 2, Objective 1</p> <p>Continue to provide a broad range of birth control methods while improving the ability to</p>	We have decided not to carry the Ortho Evra Patch and carry the NuvaRing as a high cost birth control. The nurses have been asked to confirm that the client is happy and stable on their method before giving out large quantities.

recover the cost of these methods.	
Goal 2, Objective 2 Provide ECP to clients for future use whenever appropriate.	All clients are asked if they would like an ECP for future use. Our percentage of visits where ECP was dispensed has risen slightly; however, many of our clients decline using ECP.

UNPLANNED PREGNANCIES

CURRENT CONDITION OR PROBLEM

In the process of assessing the issue of unintended pregnancies, it is clear that 5% of our continuing clients are still having positive pregnancy tests/unplanned pregnancy.

GOAL

Improve the number of continuing clients with unplanned pregnancy to 2.5% in the coming year.

ACTIVITIES

Target Population	Who	What	Timeline
Unplanned Pregnancy Clients	Family Planning Staff	Increase access to walk-in clinics. Improve triage so high-risk clients are not inadvertently turned away.	ongoing
Unplanned Pregnancy Clients	Family Planning Staff	Review and update birth control methods with staff; update protocols and best practices. Added Nuva Ring 3/04	ongoing
Unplanned Pregnancy Clients	Family Planning Staff	Review and improve client information regarding using certain birth control methods. Added NuvaRing 3/04.	ongoing
Unplanned Pregnancy Clients	Family Planning Staff	Enhance ECP program/ review literature and methodology.	ongoing
Unplanned Pregnancy Clients	Family Planning Staff	Review any new research on how to improve client compliance.	ongoing
Family Planning Staff	Family Planning Staff	Staff discussions at staff meetings on success and failures for continued improvement.	ongoing

EVALUATION

We did not meet our goal of improving the number of continuing clients with unplanned pregnancy to 2.5%. The number of unduplicated continuing clients with positive pregnancy tests/ unplanned is 3%. Although close to goal, we will continue to evaluate our initiatives and act upon what we learn to reduce this rate. This rate is established by taking the number of continuing contraceptive clients divided into the number of positive pregnancy tests/unplanned, Region X Data System Report Table AL-5.

2005 Update: The Ahler's data system made a change to the reports available due to an Oregon State request. Therefore, an exact measurement cannot be applied to this problem. Using Ahler's data report #AL-2C, continuing clients plus unplanned pregnancies from AL 26, the rate is 4%. This is an increase of 1% from last year if the data is comparable. Efforts need to continue to improve the number of unplanned pregnancies occurring in continuing clients and particularly our teen clients. Plans are underway to open a teen specific clinic late Spring or summer 2005. The intent is to provide education and support to teens in a location which might be more appropriate and during hours when teens are more available.

2006 Update: Although we cannot compare rates due to change in data, we know that according to Ahler's data report AL-5, reports indicate that of the clients using "no method" and are pregnant (unplanned), we note a reduction from 41.5 to 32.8. We have increased our use of ECP, attempting to give our clients at risk ECP for future use. We are hopeful the addition of the Downtown Health Center for young adults will eliminate more barriers to education, information and contraception for our clients.

D) Maternal Child Health Programs

BASIC SERVICES

The Health Department provided prenatal care to 280 clients in 2007 in the HealthyStart prenatal clinic, while Oregon MothersCare (OMC) provided OHP assistance and referral to 630 clients. Our Health Department provides a safety net Well-Child Clinic seeing uninsured, underinsured and rarely OHP covered children with barriers to service and emergent needs (i.e. new to area, need physical to begin Head Start). Children are seen for preventative care, sick visits, immunizations, and sports physicals. Referral is provided to OHP and families are assisted to find a medical home.

Our La Pine School Based Health Center (SBHC) is located in the parking lot of the La Pine High School and within walking distance of the middle school and elementary school. Once registered, students are able to walk in for sick visits without missing school or requiring parents to miss work to accompany them. Family planning services are not offered due to the School Board's refusal to support it in the School Based Center.

Due to collaboration with Bend/ La Pine School District, the FAN (Family Access Network) and the Health Department, a safety net clinic is offered at the Health Department and staffed by a nurse practitioner and a school nurse and FAN advocate. A similar safety net clinic is offered in partnership with Redmond schools and held at the Becky Johnson Center in Redmond.

The increasing numbers of uninsured students created demand for new School Based Health Centers and the Health Department received planning grants for new centers in Bend and Redmond. As the FAN Wellness clinics are discontinued this next school year it is hoped the SBHCs will help fill this gap.

Home visiting programs consist of Maternity Case Management in which 161 clients were served despite staffing shortages in 2006, and BabiesFirst! which saw 242 clients in 2007 of which some were also enrolled in CACOON. The Health Department contracts with Child Development and Rehab Center to provide case management services through the CACOON program to children with a medical diagnosis.

Public Health nursing staff are current on NCAST training and use these tools to assess attachment and provide parent training. Our CACOON Coordinator also participated in the Hawaii Telemedicine Grant in which local children with a medical issue were seen in Bend via teleconference and received case consultation from genetic specialists at OHSU.

Dental screening was provided by Public Health nurses for pregnant women and infants referred from WIC and our Latino Community Center. During the screening, clients received education on oral care, fluoride varnish if indicated, referral to OHP and dental care, and a dental kit (containing educational materials in English or Spanish, toothbrush, toothpaste, and Xylitol gum). The supplies were purchased with a small grant from the Oregon Dental Society.

In 2007, 42 dental screenings were held, with 329 clients seen, 302 fluoride varnish applications were applied. Our dental grant is over and staff are looking for additional funds. Currently, we are working on a collaboration with the Family Drug Court to host the Medical Teams International dental van at the Health Department.

Oregon MothersCare continues to be offered and has assisted pregnant women with OHP assistance and referral to prenatal care. In 2006 our OMC program began faxing referrals to local dentists to assist women in access to dental care. The need for OMC is much greater than our current capacity (.4 FTE), but our worker is also a WIC employee and has been able to help women with WIC certification during OMC appointments and with OHP assistance during WIC appointments which has greatly benefited coordination of care and access to services.

The Deschutes County WIC program served 2,714 families (of whom 77.2 % were working families), 2,132 women, 4,634 infants and children under 5 in 2007. 94.4% of our moms started out breastfeeding.

Perinatal

A. Problem

Maternity case management is most effective if services begin early in pregnancy but Deschutes County often receives second and third trimester referrals from community partners. Effective outcomes like smoking cessation, entrance to substance abuse treatment, adequate weight gain can be impacted most effectively with early entrance to Public Health Home Visiting services.

B. Goal

The goal is to increase the number of women served before the third trimester of pregnancy, and thereby improve pregnancy outcomes. The target is for 75% of referrals received to be first and second trimester, and for the first contact to be made within three weeks of receiving the referral.

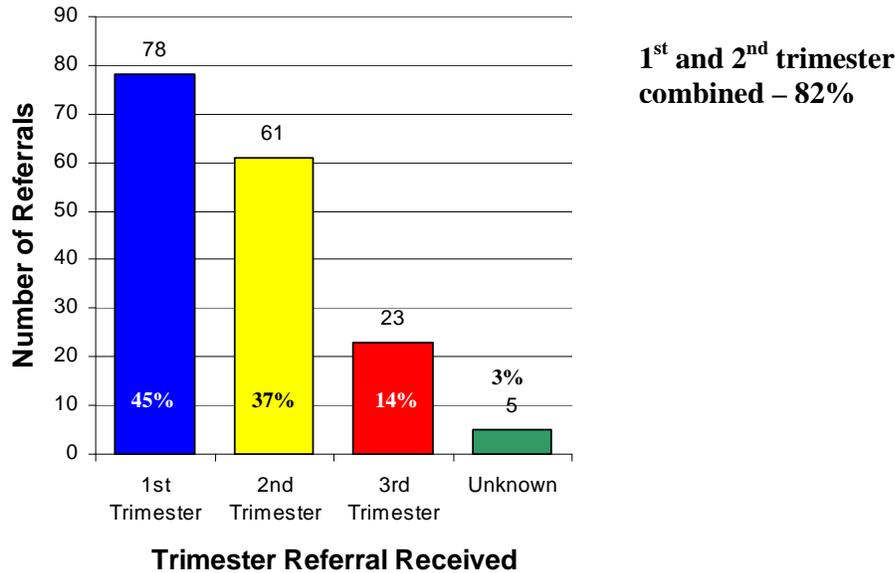
C. Activities

1. Teach Family Planning staff and front office to refer all pregnant clients with risk factors at the time of pregnancy test to Maternity Case Management.
2. Visit OB/GYN providers, Planned Parenthood and other providers of pregnancy tests to explain services and simplify the referral process.
3. Create a tracking system for PHNs to collect data on referral date and first contact date.
4. In-service at WIC staff meeting on new target and brain storm with them how to get earlier referrals (i.e. at time of call to schedule first pregnancy apt, refer).

D. Evaluation

Perform data collection, data analysis to see if additional measures are needed. Program outcomes for MCM (Maternal Case Management) will be collected in Perinatal Data sheet and analyzed at State level. Effectiveness of the referral system will be measured by percentage of clients entering MCM in first or second trimester, and number receiving full MCM package as appropriate to their risk factors.

2007 MCM clients - Number of referrals received during in 2007, by trimester received:



ENVIRONMENTAL HEALTH

(See Attached Annual Work Plan – **Appendix C**)

HEALTH STATISTICS

CURRENT CONDITION OR PROBLEM

The process and activity of conducting community health needs assessment and planning continues to evolve as an area of focus for the Department. We are proud to have delivered our third bi-annual Community Health Profile report in March of 2007. Service planning and resource allocation decisions are increasingly dependent upon current, relevant and accurate baseline data specific to the local community. The essential purpose of these requests is to assist in community needs assessments and consequently service planning. More recently the Department and community partners have recognized the value of monitoring health indicators as a means to measure the success or impact of various human service programs.

Dynamic change in the social and economic environment has created an increased need for health and social support services at a time when public revenues are limited and the health system budget is strained. This climate necessitates highly targeted service provisions to maximize the effect of programming. The Deschutes County Health Department is a proud partner in this effort and has served as a leader to stimulate dialog, planning and resources dedicated to meeting the Public Health needs of our community. Before the end of this April, the Department will deliver its second community report card. This newsletter is intended to bring attention to and stimulate interest in how local Public Health contributes to the health of our community and to keep us accountable in doing so.

The Department has not yet developed a true center of emphasis on health statistic monitoring and reporting, but has increasingly relied upon the abilities of a few key staff to produce regular updates in the form of Health Profiles. Frequent requests for specific information is assigned to the program or staff who seem most closely associated with the nature of the data being requested. This frequently results in staff having to fit the work in-between their other routine duties.

The Department has intranet and web technology at its disposal in addition to several staff who demonstrate strong technical skills in this area. A challenge is to restructure work assignments to better accommodate for this growing area of need.

In part to respond to the community's interest in Health Statistics, the Department published its third **Community Health Report** in the March of 2007 and will publish a future report in the Spring of 2009. The report, included as **Appendix A**, covers a wide variety of subject matter ranging from population statistics, infectious disease, chronic disease, child and adolescent health and preventable disease.

GOALS

Bi-Annual Health Status Report: Continue with the excellent work done in 2002 and 2004 by producing a periodic health status report which monitors the priority health issues affecting the community. This is planned for the Fall of 2006.

Annual Department Report Card/ Community Newsletter: Our inaugural report was offered to citizens in late April of 2006 and our second report is due in a matter of weeks. The report intends to reflect the scope of services provided by local Public Health and how they contribute to the health of the community. The communication is also intended to help link the Department closer to the community it serves and also to offer a means of accountability to be outstanding stewards of public resources.

Center of Emphasis in Health Statistics & Community Health: Develop resources (staff and time) dedicated to monitoring health trends and producing reports. The Director's vision includes integrating Community Health Promotion and Prevention work with Health Statistics and monitoring.

ACTIVITIES

Bi-Annual Health Status Report

Target Population	Who	What	Timeline
Deschutes County Residents	Management	We will survey our staffing capacity and talent then assign a lead role to a member of our team who can best assure managing the logistics of producing an annual report.	ongoing
Deschutes County Residents	Management	We will collect data from similar sources used in the 2002, 2004 and 2007 reports and continue with trend reporting for 2008-09.	ongoing
Deschutes County Residents	Management	We will closely align the focus of the report to compliment the Community Priorities as identified in the Comprehensive Planning Efforts associated with SB 555.	ongoing
Deschutes County Residents	Management	We will plan on producing the next report in 2009	Spring 2009

Center of Emphasis in Health Statistics

Target Population	Who	What	Timeline
Deschutes County Residents	Mgmt	We will survey the Department to determine the scope of demand for providing health statistical information to the public, other community partners and for internal operations and project work.	ongoing
Deschutes County Residents	Mgmt	Based on this assessment we will gauge the level of dedicated staff support necessary to meet this demand.	ongoing
Deschutes County Residents	Mgmt	We will structure this service to fit within a Community Health and Prevention area of focused programming as resources allow.	ongoing
Deschutes County Residents	Mgmt	We will propose a placeholder in our budget for the resources necessary to create a center of emphasis in Community Health, Prevention & Health Statistical reporting.	2008-09 Budget Cycle
Deschutes County Residents	Mgmt	We will develop a location on our Department web site which serves as a place to post and update critical health statistical information specific to Deschutes County.	By Spring of 2007
Deschutes County Residents	Mgmt	We will coordinate with the Central Oregon Health Council and the Commission on Children and Families to identify a plan of action for maintaining a wide variety of social and health performance measures.	ongoing

EVALUATION

Annual Health Status Report

We will conduct a written survey by the Fall of 2007 to determine the opinion of key community partners related to the value, need for, content and quality of the report. This will include:

- Our own Public Health Advisory Board.
- Commission on Children and Families.
- Educational Service District Team (ESD).
- Central Oregon Health Council.
- State Human Service Agency Partners.

Center of Emphasis in Health Statistics

We will assess the value of creating this type of new service from a cost versus utility perspective by the Spring of 2008. This will involve an internal assessment of the value/ efficiency of work redesign as well as assessing the value of proving data on our web site, determined by the number of "hits" to the system.

INFORMATION AND REFERRAL

CURRENT CONDITION OR PROBLEM

A significant volume of health information and referral is made across all programs and services on a daily basis. A Hepatitis scare in the 2003 resulted in over 300 phone calls from the public in just four hours. The flu vaccine shortage of 2004 resulted in a similar demand for public information. We fear these examples may pale in comparison to the daily demand for information should West Nile Virus materialize in the summer of 2005. The information disseminated within formal clinical program activity with specific clients is very accurate, complete, and targeted. However, there is certain randomness to public request, by phone, or in person that is difficult to measure. The Department does not track the frequency of requests or their nature, but has become quite adept at referring callers to resources outside the Public Health domain. A very handy brochure from our local Family Resource Center contains a wealth of service referral information and is frequently used by reception staff.

GOALS

- 1) The Department will survey for the frequency and nature of calls on a period basis.
- 2) Employee Orientation will include training on providing information and referral advice.
- 3) Employees will be provided an opportunity to provide input on methods to enhance the quality of this service.

ACTIVITIES

Target Population	Who	What	Timeline
Deschutes County Residents	Management, Front office Support Team	We will survey the Department to determine the scope and frequency of demand for providing health information and referral to the general public.	ongoing

Health Department support staff.	Management	We will continue to develop basic employee orientation materials and training related to providing health information and referral	ongoing
Deschutes County Clinical and Front office Staff.	All staff	We will implement round-table discussion within and between work teams to elicit ideas related to enhancing the quality of this service. We will document ideas and assign specific tasks as part of an overall Quality Improvement Process.	ongoing

EVALUATION

- 1) We will report to staff and our Public Health Advisory Board the results of our survey related to measuring the frequency and nature of information and referral call from the general public.
- 2) We will implement a tool to measure the satisfaction and quality of orientation materials and training from the perspective of our staff.
- 3) We will implement a tool to measure the satisfaction and quality of service from the perspective of our clients/public.
- 4) We developed a new employee orientation checklist to assure we are preparing employees to provide information and referral as appropriate.
- 5) We will incorporate staff recommendations for enhancing the quality of this service into a formal Quality Improvement Initiative for the Department. The Support Services Manager will be charged with oversight on this activity.

OTHER ISSUES

(None other than noted in previous sections)

IV. ADDITIONAL REQUIREMENTS

1. An Organizational Chart is attached. **(Enclosed as Appendix D)**
2. Senate Bill 555: The local Commission on Children and Families stands as a separate Department within the Deschutes County Organization Structure.
 - The Deschutes County Health Department continues a close partnership with the Local Commission on Children and Families (CCF) in the development of many components of the local Comprehensive Community Plan.
 - The Plan itself contains sections relevant to Public Health and consistent with the Oregon Benchmark Project. Assurance for childhood immunizations; teen pregnancy prevention, hunger prevention, oral health care, primary health smoking cessation, and cultural competency are just a few examples.

- The Health Department Administrator regularly participates in CCF planning work, is involved in the local Professional Advisory Committee to the CCF, and attends CCF executive team meetings.

V. UNMET COMMUNITY NEEDS

Primary Care

CURRENT CONDITION OR PROBLEM

There are approximately 25,000 uninsured individuals currently living in Deschutes County. This compares to estimates of approx. 14,000 just in 2002. Changes in OHP eligibility made between 2002 and now have significantly worsened this problem. To compound this situation, many local medical care providers have simply closed their practices to the few remaining adult OHP-Categorical clients and Fee-for-service Medicare clients. Our fears of a year ago have been realized as nearly 30% of our total population has severely limited or no access to basic physical health care services, mental health care, or oral health care.

La Pine, Oregon is geographically isolated from most health care services in the County and has a population of approximately 14,000, with a median family income of about \$ 24,000 and an estimated 24% unemployment rate. The area has a high percentage of older adults (over the age of 65) at 22%. Recent years have seen the demise of private practice medical practices in this Community. Even a Rural Health Clinic (RHC) established in 2003 has struggled financially in this market.

GOALS & ACCOMPLISHMENTS

1. Rural Health Clinic: In September of 2003 a Rural Health Clinic in La Pine, Oregon and was formally designated by HRSA. This practice, owned by Dr. Lisa Steffey, is estimated to have the capacity to serve approx. 6,000 to 8,000 clients, many of whom are Medicare/ Medicaid. The clinic continues to experience cash flow challenges as well as provider/ practitioner recruitment.
2. La Pine: A financial feasibility study related to establishing an FQHC in La Pine was conducted by the Ochoco FQHC clinic in Prineville. This study determined that an FQHC would be fiscally challenged with a new Rural Health Clinic just established.
3. Community Clinic of Bend: – FQHC: The Deschutes County Health Department supported planning and a grant request to HRSA by the Ochoco FQHC clinic to establish an FQHC “expansion” site in Bend. The Department made an official request to HRSA to designate an area of southeast Bend a *Medically Underserved Area*. The designation was granted and soon our friends at the Ochoco Clinic were drafting an FQHC grant request for the Bend Community. In October of 2004, HRSA provided notice of a grant award to establish a fully operational FQHC in Bend. The clinic has opened at 409 Greenwood Avenue (April 2005) and delivered over 10,000 patient visits in 2006.
3. The Volunteer’s In Medicine: (VIM) Clinic in Bend opened for clients in early April 2004, with a mission of serving low income uninsured residents of the County. The VIM clinic will have provided over 3,000 clinic visits in its first year of operation. The clinic has been an invaluable

resource to our communities. The Department’s own Community Care Clinic closed up shop in the late summer of 2004 as the VIM clinic became fully operational.

4. FAN- (Family Access Network): FAN Wellness clinics will be discontinued in fiscal year 2008-09 due to school funding cuts, but it is planned that the new School Based Health centers will continue to serve this population. The mission is to serve uninsured children. Children eligible for OHP are referred to the FQHC (Federally Qualified Health Clinic) for application assistance and care. VIM continues to have difficulty meeting the adult care need in our community and does not have capacity to serve children.
5. HealthyStart Prenatal Clinic: The Department continues to operate the HealthyStart Prenatal Clinic which serves to offer universal access to prenatal and obstetrical care for all women regardless of ability to pay. The demise of the OHP plan may result in a significant increase in demand for this safety net health service. The program served over 340 women in 2004 and provided some 120 deliveries – nearly 8% of all deliveries performed in the County.
6. A School Based Health Clinic: (SBHC) has been operating in the La Pine Community since the Spring of 2005. The clinic is operated as an extension of the Deschutes County Health Department. The Maternal Child Health Team at the local Health Department, under the leadership of Elaine Severson worked tirelessly with local school officials, school nurses and community partners to bring this clinic into fruition. Continued operation of the clinic is largely dependent upon legislative support from the Governor’s budget with proposes to expand the number of clinics in Oregon.
7. NW (Northwest) Medical Teams Dental Van: The local VIM clinic, The Central Oregon Oral Health Coalition and the La Pine Community Action Team have been instrumental in bringing the NW Medical Teams mobile dental service to Central Oregon for repeated visits. This service targets low income uninsured residents of Central Oregon and is staffed by volunteer dentists and hygienists.
8. Kemple Dental Clinic: For more than 10 years Dr. H.M. Kemple has operated a free dental clinic for the disadvantaged children of Deschutes County, serving several thousand children to date. The clinic is currently housed at the Juvenile Corrections Facility in Bend.

ACTIVITIES

Target Population	Who	What	Timeline
Deschutes County Residents	Health Department	Continue participation in community-based coalitions, counsels, steering committees and board which are dedicated to addressing access to health care for low income, and medically uninsured individuals.	ongoing
Deschutes County Residents	Health Department	Work closely with community health care leaders from the Hospital and medical clinic systems to establish a system of care of Medicaid clients.	ongoing
Deschutes County Residents	Health Department	Assess the capacity of the mid-level providers to open their practice to these	ongoing

		clients.	
Deschutes County Residents	Health Department	Establish an urban setting Federally supported Community Health Center or FQHC model in Bend	Completed
Deschutes County Residents	Health Department	Perform a financial evaluation of operating a primary care clinic through the Deschutes County Health Department. Completed in the Fall of 2004 – determined to be financially challenging.	Completed
Deschutes County Residents	Health Department	Confirmation of the level of financial, medical, specialty support, and lab/ radiology support across the medical community to assist with delivery of comprehensive health care to these individuals.	ongoing
Deschutes County Residents	Health Department	Develop a broad coalition of support from the County, Private medical market and Not-For-Profit hospital system. Establish a Central Oregon Health Care SafetyNet Coalition. This activity has recently matured into a 501c3 know as the Central Oregon Health Collaborative.	ongoing

EVALUATION

The time line for preliminary evaluation of the components related to creating a system of care for the uninsured and Medicaid-OHP clients is ongoing as the situational needs and opportunities evolve. The ultimate test of success will be measured by the number of individuals who can be served by this system, and as such, its ability to address the 'access to care' issue for an estimated 25,000 – 35,000 individuals.

Methamphetamine Abuse

CURRENT CONDITION OR PROBLEM

The current status of methamphetamine abuse is frequently referred to as “*Epidemic*”, and yet we have precious little hard data upon which to draw that conclusion. Yet, with the “hard” data we do have and given the real life testimonials of corrections officers, court officials, mental health therapist and community members it does indeed appear we have an “*Epidemic*” of sorts on our hands.

At best, the Methamphetamine abuse issue has had a huge negative impact on our courts, our corrections system, our schools and our communities. Worse, methamphetamine abuse has had a tragic impact on our families, our children, our health, our economy and may be the single most “urgent” issue impacting our communities. Methamphetamine abuse impacts us as parents, spouses, educators, employers, public officials and community members, and appears to have a pervasive presence in many if not most of the serious social issues facing us citizens.

In 2004, methamphetamine abuse accounted for 43% of all substance abuse mental health services delivered by County Mental Health. This eclipsed, for the first time ever – alcohol – as the #1

substance for which clients sought services. Local law enforcement estimates well over 80% of all property crimes are related to methamphetamine abuse. From October of 2003 to February of 2005 the amount of methamphetamine seized by local law enforcement official increased a whopping 649%. Our colleagues with State Child Protective Services indicate methamphetamine is involved in far too many child abuse and neglect cases and in nearly all cases where parental rights are terminated.

COMMUNITY CALL TO ACTION

Since early 2004 a group of dedicated volunteers have fostered community discussion, increased awareness and promoted a call to action to address the methamphetamine abuse issue. The *Methamphetamine Action Coalition* was formed on the heels of a Community Summit held in the Spring of 2004 to increase knowledge and interest in the community about methamphetamine abuse. Since that time, community leaders and public officials have taken a much keener interest in addressing this issue. Recently, the Deschutes County Mental Health Department submitted a sizable HRSA grant intended to add capacity in addressing this substance abuse issue. Planning is currently underway to try to establish a formal community-wide prevention and education effort to curb this epidemic.

Hunger and Nutritional Health

This is a very significant problem for many of our families and children. While the County population increased 24% from 2000-2005 the number of people accessing food bank programs each month increased by 45% during this same period. School District data suggest some primary schools have greater than 60% of their students on public assistance meal programs. Unemployment and poverty in some areas of our County approaches 25% of the individuals living there. Hunger is a very real problem.

Tobacco and Drug Addiction

The elimination of the Measure 44 funded Tobacco Prevention program presented an immediate and significant Public Health issue. The success of the program was well documented and we are now faced with regaining lost ground as the incidence of tobacco use by youth has risen in the face of the programs demise. Fortunately, Deschutes County is one of several that have received partial re-funding of the Tobacco Prevention Program. Much more could be done to prevent the health effects of exposure to tobacco products.

Mental Health Services for Uninsured

The elimination of many behavioral health supports for our citizens needing these services present very real Public Health issues. Untreated behavioral health illness will have a cascading effect on public safety, employment, stable home environment and personal self-adjustment.

Family Violence

The rapid rise in family violence incidents speaks loudly to the unmet need in this area. Deschutes County's rate of family violence well exceeds recent State averages. It is a system crying out for resources, at a time when social service supports in this area are being de-funded.

Children With Special Health Care Needs

Services for these very special children once again make the list of one of the most tragically under funded needs in our communities. Public and School Health Nurses continually struggle to find resources, in terms of medical care access, respite care, treatment and durable medical equipment to help meet the needs of these children.

Health and Social Support Assets for Ex-Incarcerated Populations

Studies indicate a lack of basic human support assets stand as a significant barrier to successful re-entry for ex-incarcerated population. A coalition of community agencies as a group has begun to look at crafting a program specifically for adult women to aid in this endeavor.

Children's Oral Health

As of September of 2004, Deschutes County ranked as one of the "10 worst" Counties Statewide for untreated dental disease in children. In schools where more than 30% of Students are on Free/Reduced lunches, decay rates are generally 400% higher than in the more affluent student population. This situation applies to many of our area schools, most especially in La Pine. This fact speaks miles to the relationship between poverty and oral health care in our children. In Deschutes County 55% of 6-8 year olds have a history of dental decay and a full 29% of these children have untreated dental decay. Dental Disease accounts for 5.7 missed days of school for every 100 of our Deschutes County school children. Efforts to raise community awareness, to reach high-risk populations, and to discuss the merits of Community water fluoridation are currently underway.

Childhood Obesity

The increasing prevalence of overweight children and adults across the United States and in Deschutes County is a major Public Health concern. Approximately 70% of Oregon deaths are due to chronic disease in which obesity is a primary risk factor. Since 1970 there has been a 200% increase in the prevalence of obesity among all children and a whopping 300% increase among teens. In a 2004 report, 28% of Oregon 8th graders were identified as overweight. Per capita soft drink consumption has more than doubled in the past 30 years and one fourth of all vegetables eaten in the United State are French Fries. If we are unable to get our arms around this large problem we face dire health consequences in the years ahead. The burden of this morbidity will impact not only the health of the nation but will likely bankrupt an already overtaxed health care financial system.

VI. BUDGET

A copy of our requested budget is attached as **Appendix E**. Note that at this time the Department anticipates delivering a balanced budget by working down some contingency funds and emphasizing collectable revenue in FY 08-09.

VII. MINIMUM STANDARDS

To the best of our knowledge we are in compliance with these program indicators according to the Minimum Standards for Local Health Departments:

Organization

1. Yes No A Local Health Authority exists which has accepted the legal responsibilities for Public Health as defined by Oregon Law.
2. Yes No The Local Health Authority meets at least annually to address Public Health concerns.
3. Yes No A current organizational chart exists that defines the authority, structure and function of the local Health Department; and is reviewed at least annually.
4. Yes No Current local Health Department policies and procedures exist which are reviewed at least annually.
5. Yes No Ongoing community assessment is performed to analyze and evaluate community data.
6. Yes No Written plans are developed with problem Statements, objectives, activities, projected services, and evaluation criteria.
7. Yes No Local health officials develop and manage an annual operating budget.
8. Yes No Generally accepted public accounting practices are used for managing funds.
9. Yes No All revenues generated from Public Health services are allocated to Public Health programs.
10. Yes No Written personnel policies and procedures are in compliance with Federal and State laws and regulations.
11. Yes No Personnel policies and procedures are available for all employees.
12. Yes No All positions have written job descriptions, including minimum qualifications.
13. Yes No Written performance evaluations are done annually.
14. Yes No Evidence of staff development activities exists.
15. Yes No Personnel records for all terminated employees are retained consistently with State Archives rules.
16. Yes No Records include minimum information required by each program.
17. Yes No A records manual of all forms used is reviewed annually.
18. Yes No There is a written policy for maintaining confidentiality of all client records which includes guidelines for release of client information.

19. Yes No Filing and retrieval of health records follow written procedures.
20. Yes No Retention and destruction of records follow written procedures and are consistent with State Archives rules.
21. Yes No Local Health Department telephone numbers and facilities' addresses are publicized.
22. Yes No Health information and referral services are available during regular business hours.
23. Yes No Written resource information about local health and human services is available, which includes eligibility, enrollment procedures, scope and hours of service. Information is updated as needed.
24. Yes No 100% of birth and death certificates submitted by local Health Departments are reviewed by the local Registrar for accuracy and completeness per Vital Records office procedures.
25. Yes No To preserve the confidentiality and security of non-public abstracts, all vital records and all accompanying documents are maintained.
26. Yes No Certified copies of registered birth and death certificates are issued within one working day of request.
27. Yes No Vital statistics data, as reported by the Center for Health Statistics, are reviewed annually by local Health Departments to review accuracy and support ongoing community assessment activities.
28. Yes No A system to obtain reports of deaths of Public Health significance is in place.
29. Yes No Deaths of Public Health significance are reported to the local Health Department by the Medical Examiner and are investigated by the Health Department.
30. Yes No Health Department administration and County medical examiner review collaborative efforts at least annually.
31. Yes No Staff is knowledgeable of and has participated in the development of the County's emergency plan.
32. Yes No Written policies and procedures exist to guide staff in responding to an emergency.
33. Yes No Staff participate periodically in emergency preparedness exercises and upgrade response plans accordingly.
34. Yes No Written policies and procedures exist to guide staff and volunteers in maintaining appropriate confidentiality standards.

35. Yes No Confidentiality training is included in new employee orientation. Staff includes: employees, both permanent and temporary, volunteers, translators, and any other party in contact with clients, services or information. Staff sign confidentiality Statements when hired and at least annually thereafter.
36. Yes No A Client Grievance Procedure is in place with resultant staff training and input to assure that there is a mechanism to address client and staff concerns.

Control of Communicable Diseases

37. Yes No There is a mechanism for reporting Communicable Disease cases to the Health Department.
38. Yes No Investigations of reportable conditions and Communicable Disease cases are conducted, control measures are carried out, investigation report forms are completed and submitted in the manner and time frame specified for the particular disease in the Oregon Communicable Disease Guidelines.
39. Yes No Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or Communicable Disease case received.
40. Yes No Access to prevention, diagnosis, and treatment services for reportable Communicable Diseases is assured when relevant to protecting the health of the public.
41. Yes No There is an ongoing/ demonstrated effort by the local Health Department to maintain and/ or increase timely reporting of reportable Communicable Diseases and conditions.
42. Yes No There is a mechanism for reporting and following up on zoonotic diseases to the local Health Department. **(for some yes, others no)**
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, or more frequently based on epidemiological risk.

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. **The County has recently adopted a 25 foot smoke free entrance policy to all County buildings.**

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 Juvenile Corrections Health
75. Yes No Clients identified at nutritional risk are provided with or referred for appropriate interventions. **(Limited)**
76. Yes No Culturally and linguistically appropriate nutritional education and promotion materials and methods are integrated within programs.
77. Yes No Local Health Department supports continuing education and training of staff to provide effective nutritional education.

Older Adult Health

78. Yes No Health Department provides or refers to services that promote detecting chronic diseases and preventing their complications.
79. Yes No A mechanism exists for intervening where there is reported elder abuse or neglect.
80. Yes No Health Department maintains a current list of resources and refers for medical care, mental health, transportation, nutritional services, financial services, rehabilitation services, social services, and substance abuse services.
81. Yes No Prevention-oriented services exist for self health care, stress management, nutrition, exercise, medication use, maintaining activities of daily living, injury prevention and safety education. **(These exist within the private and/or non-profit community but not for all of these are available within the local Health Department).**

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. **(limited to MCH programs & WIC via Dental varnish)**
92. Yes No Injury prevention services are provided within the community.

Primary Health Care

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

Cultural Competency

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

Health Department Personnel Qualifications

103. Yes 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.

104. Yes No The local Health Department Supervising Public Health Nurse(s) 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.

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.

106. Yes X No ___ The local Health Department Health Officer meets minimum qualifications:

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

The Department has recently matured to a Medical Director model of oversight with two physicians designated with equal responsibility/authority over specific programmatic areas. Dr. Richard Fawcett is our lead Health Officer, Dr. Mary Norburg is Deputy Health Officer.

VIII. SUMMARY ASSURANCE

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

Local Public Health Authority

Deschutes County

May 1, 2008
Date

DESCHUTES COUNTY

ENVIRONMENTAL HEALTH DIVISION

**WORK PLAN
2008 - 2009**





ENVIRONMENTAL HEALTH DIVISION

Provide and promote protection of Public Health and the Environment through education, consultation, and regulation.

The Environmental Health Division (EH) provides plan review, consultation and inspection of regulated public facilities (restaurants, pools, tourist facilities, schools and day care centers) and on-site wastewater and dispersal systems. The Division also regulates public water systems to provide safe drinking water and works with the County Health Department on a variety of epidemiology issues.

ADMINISTRATION

GOAL: Maintain a healthy work environment, which promotes an atmosphere of collaboration, education, and high morale among the Environmental Health staff.

Objectives:

1. Cross train staff to provide back-up in pool and spa, water system, facility licensing, and plan review programs.
2. Continue to learn and fine tune the processes required for licensing and tracking all EH functions through our data bases.
3. Develop code enforcement procedures for the newly deputized sanitarians.
4. Continue to update the Web site to provide useful information to the public about EH programs.

ON-SITE WASTEWATER TREATMENT

Goal: To provide homeowners who are served by On-Site Wastewater Treatment systems with an Operation and Maintenance (O&M) oversight program that is practical and effective. Operation and Maintenance tracking and reporting is mandatory as per OAR 340-71 for Alternative Treatment Technology (ATT), which the County is contracted to regulate.

Objectives:

1. Fine tune data base and office processes to efficiently track O&M activities.

2. Develop a plan for follow-up of time of sale transfers and non-compliant systems as required by OAR 71

3. Provide fee incentives for homeowners whose systems receive the proper O&M.

Goal: Maintain a service turn around average of 10 calendar days for issuance of approximately 1,800 annual permits; 30 calendar days for approximately 500 annual site evaluations; and 2 days for the 2,400 annual field inspections.

Objectives:

1. Become more efficient in our permit review and standardize inspection processes.
2. Develop checklists so front counter technicians can help ensure a more efficient operation.

Goal: To better communicate with the Department of Environmental Quality (DEQ).

Objectives:

1. Amend contract and/or a memorandum of understanding with the DEQ to agree on a process to come to a resolution on several issues.
2. Work with other County on-site administrators to discuss common problems in administrating the On-site program.

Goal: To communicate better with our customers

Objectives:

1. Design an "easier to read" permit format, which will include standardized inspection procedures.
2. Design an application questionnaire to better understand what the applicant is proposing.
3. Print and mail two newsletters to the installers.
4. Clarify easement procedures by creating an information sheet.
5. Create an information sheet concerning Recreational Vehicle (RV) waste.
6. Research ways to provide treatment and disposal of low volumes of animal enclosure waste and water softener waste, which are not now regulated.

Goal: Communicate better with each other.

Objectives:

1. Provide two sets of South County water table maps for staff reference.
2. Create a complete book of all Alternative Treatment Technology information.
3. Create a collection of approved product and application information for the Sanitarians quick reference.

GROUNDWATER PROTECTION PROGRAM FOR SOUTH DESCHUTES COUNTY

Goal: Apply the tools, experience, and information gained from the La Pine National Demonstration Project and the County Regional Problem Solving Project to identify and implement solutions to protect and improve the quality of the sole source of drinking water in South Deschutes County.

The grant has expired but contingent on adoption of the Local Rule the following objectives remain.

Objectives:

1. Contingent upon adoption and implementation of the Local Rule provide homeowners and installers with updated information about de-nitrifying technologies.
2. Contingent upon adoption and implementation of the Local Rule assist homeowners by individually evaluating lots for the purpose of determining components needed to meet the upgrade requirement of the local ordinance.
3. Contingent upon adoption and implementation of the Local Rule evaluate newly approved technology for de-nitrifying capabilities.
4. Assist planning with "High Groundwater Lot Work Plan" as provided in planning's work plan. Implement distribution of the Partnership funds created by the Pollution Reduction Credits as directed by the BOCC

FOOD SERVICE FACILITIES

Goal: To provide operators of food service facilities with the education and tools to protect the public from food-borne illness.

Objectives:

1. Educate staff on identifying risk in food handling practices commonly found in food establishments.

2. Allow for one Environmental Health Specialist per year to train and be certified as a Standardized Inspection Officer by the Department of Human Services (DHS) to ensure greater consistency in licensed facility inspections.
3. Design and implement a Web page for access to food inspection reports.
4. Implement on-line food handler training.
5. Perform either self-assessment or baseline survey for the Food and Drug Administration's (FDA) Voluntary National Food Regulatory Standards Program.
6. Send a newsletter to licensed restaurant and mobile food unit owners annually.
7. Perform 100% of required inspections on all licensed food service establishments.
8. Implement the survey "Foodborne Illness Risk Factors and Public Health Interventions" into each semi-annual restaurant inspection.
9. Improve efficiency and tracking ability of newly built inspection system.

POOLS AND SPAS

Goal: Provide oversight and education to all public pools and spas operators and to protect the public from water-borne disease.

Objectives:

1. Provide clear and detailed handouts to help educate pool and spa operators on troublesome issues regarding pool and spa maintenance.
2. Create an educational approach to routine inspections.
3. Provide EH staff with opportunities to:
 - Gain pool and spa inspection experience
 - Add to the diversity of understanding of pool management and chemical handling through continuing education
 - Learn effective communication methods targeting pool and spa operators
4. Provide educational material to pool operators about changes to the wading pool rules. Investigate the effectiveness of a County ordinance to regulate continuing non-compliers.
5. Ensure Deschutes County representation to any State committee formed to discuss rental housing pool and spa facilities.

DRINKING WATER

Goal: Assure all citizens of Deschutes County safe drinking water by implementing and enforcing drinking water standards through efficient technical and regulatory assistance of the 175 public water systems.

Objectives:

1. Maintain current level of customer service for public health and drinking water inquiries.
2. Continue to keep the number of Significant Non Complier (SNC) systems to an absolute minimum.
3. Add 47 additional small public water systems to the inventory per the 2008 State contract amendment.
4. Increase sanitary survey rate of 41 per year to keep up with the required increased inspection frequency and the added water systems.
5. Earn 90% or more of Drinking Water State Revolving Fund allocation.
6. Ensure the public receives safe water during temporary events.
7. Train additional staff in the water program.
8. Consult, receive, and review the remaining Emergency Response Plans not yet submitted by 21 water systems.

HEALTH DEPARTMENT

Goal: To aide the Deschutes County Health Department (DCHD) in their mission to provide public health services to the community.

Objectives:

1. Maintain the high level of communication with the DCHD by continuing to attend meetings with them to discuss public health needs and how the Division and DCHD can work together to meet those needs.
2. Assist the DCHD in food-borne illness investigations.
3. Help DCHD and County disaster preparedness teams by becoming a part of the emergency response plans.

**HEALTH DEPT - COMBINED PROGRAM TOTALS
FY09 BUDGET PROPOSED**

FY09 BUDGET PROPOSED

REVENUES			
301	00	00	Beg.Net (Carry Over) 707,000.00
332	15	00	Medicare Reimbursement 4,000.00
334	12	00	State Grant 1,593,814.00
334	14	00	Child Dev & Rehab Ctr 34,737.04
335	11	00	State Miscellaneous 230,550.00
335	17	00	State Pmt /Shared Rev/OMAP 270,000.00
335	48	00	Family Planning Exp Prj (FPEP) 475,000.00
343	12	00	Contract Payments 8,000.00
345	13	00	Patient Ins Fees 91,450.00
345	14	00	Patient Fees 222,500.00
345	18	00	Vital Records-Birth 40,000.00
345	19	00	Vital Records-Death 94,000.00
361	11	00	Interest 38,000.00
365	11	00	Donation 9,100.00
370	10	00	Interfund Contract (Prenatal) 113,160.00
371	11	00	Drug Court - Byrne 40,082.00
391	11	00	From General Fund 2,591,235.91
391	61	00	From Gen Fund - other 25,000.00
TOTAL REVENUES:			6,587,628.95

EXPENDITURES			
PERSONNEL			
441	10	06	Health Officer/Med Exam. 40,000.00
441	10	14	Health Svc Administrator 117,018.00
441	10	19	Physician Clinical Svcs 8,100.00
441	12	39	Project Coordinator 22,834.00
441	12	41	Program Dev Specialist 77,489.00
441	16	05	Clinic Prgm Supervisor 73,081.00
441	16	07	PH Nurse III 105,667.00
441	16	08	PH Nursing Prm Manager 147,733.00
441	16	10	PH Nurse II 654,432.00
441	16	12	HS Nurse LPN 3,947.00
441	16	13	Lab Technician 8,681.00
441	16	14	Medical Asst. 44,899.00
441	16	16	Nurse Practitioner 231,589.00
441	16	17	WIC Supervisor 58,792.00
441	16	18	WIC Certifier 136,098.00
441	16	19	Nutritionist 100,392.00
441	16	21	Health Educator II 191,566.00
441	16	22	Health Educator I 19,396.00
441	16	24	Comm Outreach Worker 10,614.00
441	16	99	Patient Acct Specialist 68,760.00
441	18	22	Admin Supervisor I 42,644.00
441	18	67	Admin Supervisor II 48,928.00
441	18	69	Registered Health Info Tech 33,925.00
441	18	71	Pt Accts Spec II 31,370.00

**HEALTH DEPT - COMBINED PROGRAM TOTALS
FY09 BUDGET PROPOSED**

				FY09 BUDGET PROPOSED
441	18	72	Time Management	22,000.00
441	18	77	On-Call	40,000.00
441	18	84	Sr Admin Secretary	40,031.00
441	18	85	Administrative Secretary	41,291.00
441	18	92	Accounting Clerk III	31,422.00
441	18	96	Medical Records Tech	27,427.00
441	18	97	Sr Med Office Asst	115,959.00
441	18	98	Med Office Asst	258,370.00
441	19	15	Cell Phone Allow	950.00
441	21	10	Life/Disability Ins.	19,834.00
441	21	50	Health/Dental Ins.	807,245.00
441	22	01	FICA/Medicare	208,753.00
441	23	01	PERS - Employee/Employer	518,612.00
441	25	01	Unempl.Ins.	12,018.00
441	26	01	Worker's Comp. Ins.	38,660.00
441	29	01	Retiree Health I	1,434.00
441	29	06	Admin Fees Section 125	1,122.00
TOTAL PERSONNEL				4,463,083.00

MATERIALS / SERVICES:

441	31	10	Mgmt Consultant	5,200.00
441	33	82	Public Information	1,500.00
441	33	99	Contract	5,000.00
441	34	04	Medical Lab.	27,950.00
442	34	06	Mailing Service (from Bldg Svcs)	7,300.00
441	34	11	Interpreter	100.00
441	34	20	Temp Help-Admin,Mgmt,Off	22,453.00
441	34	26	Education Provider	500.00
441	34	37	Facilitation	3,000.00
441	35	05	Archive Fees	1,000.00
441	35	65	Interfund Contract (Finance)	8,000.00
441	36	20	Building Services	157,215.00
441	36	25	Admin Svcs	27,379.00
441	36	28	Int Svcs/BOCC	28,466.00
441	36	30	Finance	35,103.00
441	36	40	Legal Counsel	20,530.00
441	36	50	Personnel	56,231.00
441	36	60	Information Services	159,775.00
441	36	61	Int Svcs/Tech Re Citrix	20,559.00
441	41	10	Water & Sewer	2,500.00
441	42	10	Garbage	2,390.00
441	42	20	Custodial/Janitorial	600.00
441	42	60	Dry Cleaning-Uniforms	150.00
441	42	70	Cleaning Svc/Car Wash	75.00
441	43	10	Software Maint	25,000.00
441	43	20	Build.Rep/Maint.	7,000.00
441	43	25	Vehicle Repair & Maint	3,000.00

**HEALTH DEPT - COMBINED PROGRAM TOTALS
FY09 BUDGET PROPOSED**

FY09 BUDGET PROPOSED

441	43	30	Equip(non-office) R/M	500.00
441	43	40	Equip (Office)	1,100.00
441	43	45	Maintenance Agreements	3,995.00
441	44	10	Copy Machine Rental	10,500.00
441	44	30	Vehicle Lease	24,000.00
441	44	40	Equipment rental	100.00
441	44	60	Building Rental	9,855.00
441	44	65	Fair/Trade Show	50.00
441	50	10	Membership & Dues	5,594.74
441	50	20	Prof. Licenses & Fees	2,610.00
441	50	30	Conferences & Seminars	13,150.00
441	50	40	Education & Training	61,520.00
441	50	41	Tuition Reimbursement	3,000.00
441	50	50	Bank & Trustee Fees	3,275.00
441	50	70	Software License	2,450.00
441	52	10	Gen. Liability Charges	27,312.00
441	52	20	Prop. Damage Charges	6,087.00
441	52	30	Vehicle Ins. Charges	3,960.00
441	53	10	Telephone/ WIC Pagers	18,750.00
441	53	11	Data Lines	5,250.00
441	53	30	Cellular	5,100.00
441	54	01	Advertising	6,100.00
441	54	10	Announcements	100.00
441	55	10	Printing/Binding-Gen.	21,351.00
441	58	20	Travel-Meals	7,450.00
441	58	30	Travel-Accommodations	16,100.00
441	58	40	Travel-Airfare	5,000.00
441	58	50	Travel Ground Transp.	600.00
441	58	60	Travel-Car Rental	3,050.00
441	58	70	Mileage Reimb.	15,585.00
442	59	20	Grants/ Contributions	25,000.00
441	59	25	Medical Projects	26,776.00
441	59	85	Local Match - TCM	95,000.00
441	59	98	Refunds/Adjustments	1,600.00
441	61	04	Computer Supplies	2,025.00
441	61	22	Educational Supplies	4,368.00
441	61	34	General Supplies	725.00
441	61	37	Laboratory Supplies	9,150.00
441	61	43	Medical Supplies	40,250.00
441	61	46	Medication & Drugs	177,300.00
441	61	55	Office and Copier supplies	30,845.00
441	61	61	Postage/Freight Out	25,175.00
441	61	70	Program Supplies	7,721.00
441	61	79	Safety Supplies	500.00
441	61	85	Software Supplies	1,120.00
441	61	99	Vaccine	35,000.00
441	62	10	Electricity (from Bldg svcs)	15,000.00

**HEALTH DEPT - COMBINED PROGRAM TOTALS
FY09 BUDGET PROPOSED**

				FY09 BUDGET PROPOSED
441	62	20	Gasoline/Diesel/Oil	5,650.00
441	62	40	Natural Gas (from bldg svcs)	7,000.00
441	63	20	Meeting Supplies	9,527.21
441	64	10	Subscriptions	750.00
441	64	20	Books	2,715.00
441	64	40	Videos	1,100.00
441	66	10	Signage	500.00
441	66	50	Minor Tools/Equip.	1,600.00
441	66	60	Minor Off.Furn.&Fixt.	3,590.00
441	66	65	Minor Off. Equipment	2,185.00
441	66	70	Computers & Peripherals	10,050.00
441	95	01	SAM	-
TOTAL MATERIALS/SVCS.				1,453,692.95
CAPITAL OUTLAY & TRANSFERS OUT				
441	92	10	Building Remodel	25,000.00
491	96	06	Project Development	150,000.00
TOTAL CAPITAL OUTLAY				175,000.00
TOTAL EXPENDITURES				6,091,775.95
501	97	01	CONTINGENCY	495,853.00
511	98	01	UNAPPR.END.FUND BAL	-
TOTAL REVENUE				6,587,628.95
TOTAL EXPENDITURE				6,587,628.95
NET BALANCE				-

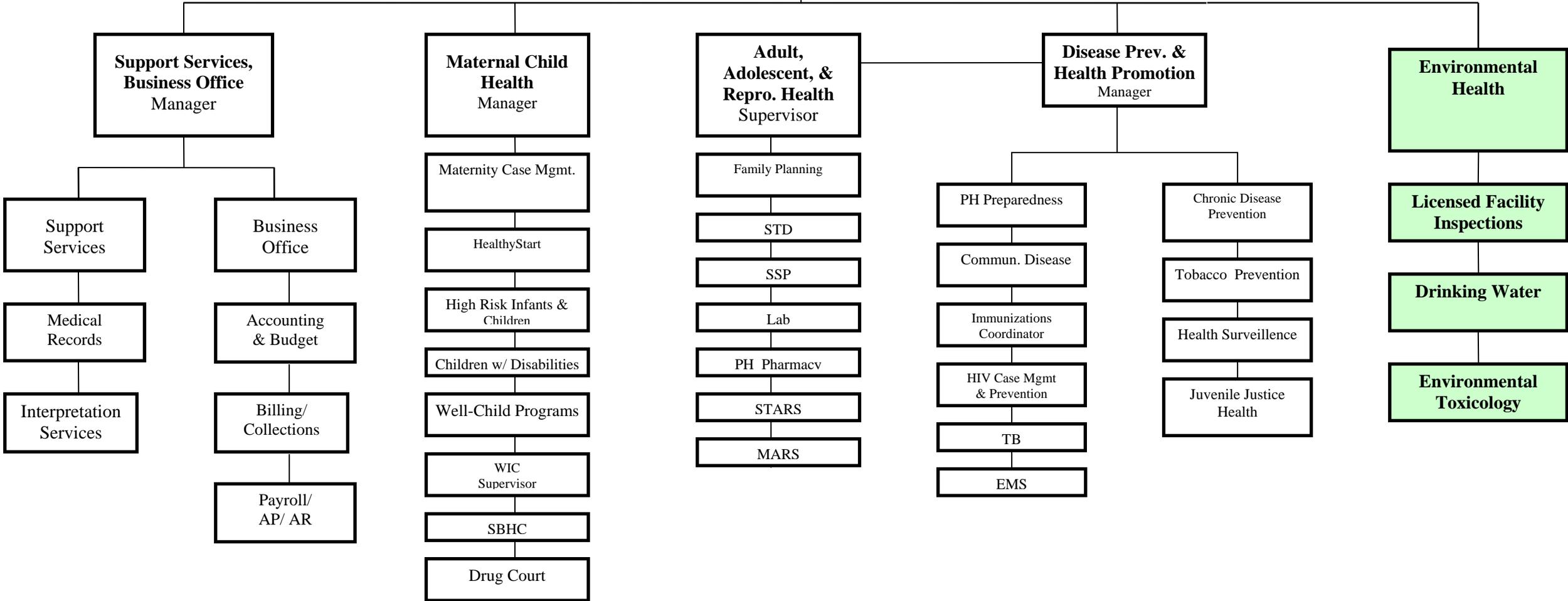
Deschutes County Health Department
Organizational Structure

Board of Health
Board of County Commissioners

Public Health Advisory Board

Health Department Director
Dan Peddycord

Medical Directors/ Health Officers



Needs Assessment for Deschutes County WIC NE Plan 2007-2008

Deschutes County WIC:

2006 Pregnancy Nutrition Surveillance Survey(PNSS)

- 40.1% Prenatal clients are overweight pregravid (46% statewide, 2nd lowest in OR)
- 48.3% have a prenatal weight gain higher than ideal (47% statewide)

2007 Review of risk factor prevalence data:

- High maternal weight gain and Overweight pregavid are top 2 nutrition risk factors for women.

National Trends:

- Weight gain less than ideal is decreasing
- Weight gain more than ideal is increasing
- Focus has changed from prevention of low weight gain to prevention of excessive weight gain.

Concerns and risks:

- Increase in pregnancy complications:
 - Gestational diabetes
 - Preeclampsia and other hypertensive disorders of pregnancy
 - Macrosomia (increased BW is positively associated with the risk of overweight and obesity later in life)
 - C-section and higher incidence of anesthetic and postoperative complications
 - Perinatal mortality
 - Baby born with congenital malformations
- Increased risk of maternal obesity, predictors of diabetes and heart disease
- Maternal weight gain after first pregnancy complicates second.

IOM Guidelines:

The 1990 IOM report remains the standard for clinical recommendations regarding gestational weight gain. They were motivated by evidence that low weight gain in pregnant women may cause low birth weight. Since the publication of the report, things have changed and an update is needed. A report (Reexamination of IOM Pregnancy Weight Guidelines) is expected to be released by June 2009. Also examine ways to enhance awareness and adoption of the guidelines.

What Works?

- Preconception counseling
- Tight monitoring of weight gain, tracking weight gain throughout pregnancy
- Long-term follow-up
- Medical advice
- Nutrition counseling
- Home visits providing prenatal education and support
- Postpartum exercise classes
- Support/discussion groups
- Breastfeeding

References:

1. Predicting preschooler obesity at birth: the role of maternal obesity in early pregnancy. *Pediatrics*. 2004 Jul;114(1):e29-36
2. Stages of change for weight management in postpartum women. *J Am Diet Assoc*. 2004 Jul;104(7):1102-8.
3. Obesity and pregnancy: complications and cost. *Am J Clin Nutr*. 2000 May;71(5 Suppl):1242S-8S
4. Medically advised, mother's personal target, and actual weight gain during pregnancy. *Obstet Gynecol*. 1999 Oct;94(4):616-22.
5. Interventions to improve diet and weight gain among pregnant adolescents and recommendations for future research. *Am Diet Assoc*. 2006 Nov;106(11):1825-40.
6. Impact of perinatal weight change on long-term obesity and obesity-related illnesses *Obstet Gynecol*. 2005 Dec;106(6):1349-56.
7. Pregnancy weight gain and postpartum loss: avoiding obesity while optimizing the growth and development of the fetus. *J Am Med Womens Assoc*. 2001 Spring;56(2):53-8.
8. Factors influencing inadequate and excessive weight gain in pregnancy: Colorado, 2000-2002. *Matern Child Health J*. 2006 Jan;10(1):55-62.
9. Gestational weight gain and postpartum behaviors associated with weight change from early pregnancy to 1 y postpartum. *Int J Obes Relat Metab Disord*. 2003 Jan;27(1):117-27
10. Pregnancy-related weight gain--a link to obesity? *Nutr Rev*. 2004 Jul;62(7 Pt 2):S105-11.
11. Trends in pregnancy weight gain within and outside ranges recommended by the Institute of Medicine in a WIC population. *Matern Child Health J*. 1998 Jun;2(2):111-6.

12. Impact of Perinatal Weight Change on Long-Term Obesity and Obesity-Related Illnesses

Obstetrics and Gynecology 2005;106:1349-1356

13. Country Development and the Association between Parity and Overweight

International Journal of Obesity 2007;31:905-812

14. Postpartum Weight Control: A Vicious Cycle

Journal of the American Dietetic Association January 2007;Vol. 107:37-40

FY 2008 - 2009 WIC Nutrition Education Plan Form

County/Agency: Deschutes County
Person Completing Form: Laura Spaulding and Janet Harris
Date: April 16, 2008
Phone Number: 541-322-7450
Email Address: lauras@deschutes.org or janeth@deschutes.org

Return this form electronically (attached to email) to: sara.e.sloan@state.or.us
by May 1, 2008
Sara Sloan, 971-673-0043

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

Year 2 Objective: During 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:

By October 31, 2008, staff will review the Oregon WIC Key Nutrition Messages and identify which one's they need additional training on.

Resources: American Academy of Pediatrics, MyPyramid.gov, Maternal and Child Health Oral health website – <http://www.mchoralhealth.org/Openwide/> Information from the 2008 WIC Statewide meeting.

Implementation Plan and Timeline: Once the Oregon WIC Key Nutrition Messages are sent to us, we will review them as a group and decide which ones we need additional training on. We will use the “informal discussion” format during our monthly staff meetings to address questions and review how these changes may influence our NE messages. All will be accomplished by October 31, 2008.

Activity 2:

By March 31, 2009, staff will review the proposed food packages changes and:

- Select at least three food packages modifications (for example, addition of new foods, reduction of current foods, elimination of current foods for a specific category),
- 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 WIC's reasoning for the change and/or reduce client resistance to the change.

Resources: WIC Works Website WIC food package materials, Information from the 2008 WIC Statewide meeting, State provided materials.

Implementation Plan and Timeline: As a group, all WIC staff will prioritize the food package modifications and participate in informal discussions regarding reasons behind the changes, how they relate to WICs key nutrition messages and how we need to modify our nutrition messages to our clients, individuals and groups. We will review the three top priorities first; however, over time, we feel it will be necessary to review all of the food package modifications and how each of them may alter our current nutrition education messages. The first three will be reviewed by March 31, 2009.

Activity 3:

Identify your agency training supervisor(s) and projected staff in-service training dates and topics for FY 2008-2009. Complete and return Attachment A by May 1, 2008.

See Attachment A

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

Year 2 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 ones they need additional training on.

Implementation Plan and Timeline:

By September 30, 2008, staff will review the diet assessment steps from the Dietary Risk Module and identify which ones they need additional training on. We have reviewed this module periodically over the last several months at our staff meetings and will continue to do so.

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.

Resources include: State provided guidance and assessment tools.

Implementation Plan and Timeline:

We have reviewed the Nutrition Risk Module and Dietary Risk Module at monthly staff meetings over the past several months. Because we are also involved in the Motivational Interviewing grant, we have updates/discussions monthly on this topic. We will continue to roleplay, review case studies, provide feedback and conduct informal discussions on an ongoing basis.

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

Year 2 Objective:

During 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 2007-2012.

Activity 1:

Identify your setting, objective and strategy to facilitate healthy behavior change for WIC staff.

Setting: Worksite

Objective: III. By 2012, increase by five percent the number of employees who are physically active for 30 minutes a day, at least five days per week.

Strategy: C. Provide and promote flexible time policies to allow for opportunities for increased physical activity.

Resource: Attachment B - A Healthy Active Oregon: Statewide Physical Activity and Nutrition Plan 2007-2012, Recommended Objectives and Strategies

Implementation Plan and Timeline: Include why this objective was chosen, what you hope to change, how and when you will implement the strategy, and how you will evaluate its effectiveness.

This objective was chosen because several staff members have shared that they do not have time to exercise before or after work so we are going to support them in planning time throughout their workday to fit physical activity in. We hope to continue to enhance a culture that already values physical activity and move it to also supporting individuals as they overcome barriers to daily exercise. By July 1, 2008, everyone will have the opportunity to adjust their scheduling templates to accommodate breaks for physical activity. We will also develop an "Exercise Tool Box" that contains a mat, stretchy bands, resistance cord, ball, etc. that will be available for use by all staff if they choose to exercise indoors. Evaluations will come through anecdotal information from staff and will be reported on next year's NE evaluation plan.

Activity 2:

Identify your setting, objective and strategy to facilitate healthy behavior change for WIC clients.

Setting: Home/Household

Objective: IV By 2012, decrease television and other screen time for children. Specifically, reduce by two percent the number of children ages 2-18 who have more than two hours a day of screen time and work to ensure children 2 years and younger have no screen time.

Strategy: We will promote Turn off the TV week in April 2009. In 2008, we will have at least one of our Quick WIC class themes be “Less Screen Time.”

Resource: Attachment B - A Healthy Active Oregon: Statewide Physical Activity and Nutrition Plan 2007-2012, Recommended Objectives and Strategies

Implementation Plan and Timeline: Include why this objective was chosen, what you hope to change, how and when you will implement the strategy, and how you will evaluate its effectiveness.

We participated in the state “screen time” survey a couple of years ago and all of our staff was shocked when we found out how much TV kids actually watch and how many very young children (<2 y/o) have television sets in their rooms. Staff voted in favor of this objective in hopes of both decreasing screen time and also replacing that time with physical activity.

We will promote Turn off the TV week in April 2009. In 2008, we will have at least one of our Quick WIC class themes be “Less Screen Time.” We will pursue administering a survey in May, 2009 that is the same as (or at least similar to) the state survey administered a couple of years ago. We will ask Julie Reeder for assistance.

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

Year 1 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 2007-2012.

Resource: Attachment B - A Healthy Active Oregon: Statewide Physical Activity and Nutrition Plan 2007-2012, Recommended Objectives and Strategies

Activity 1:

Setting: Home/Household

Objective: Objective I. By 2012, maintain the current level of breastfeeding initiation and increase by two percent a year the number of mothers who breastfeed exclusively for the first six months of a child's life.

Strategy: Our IBCLC will conduct community/workplace programs using the "Business Case for Breastfeeding" toolkit to assist mothers in continuation of breastfeeding while returning to work. We will also have ongoing training w/our clerks to field calls from exclusively breastfeeding moms who are requesting formula and refer them appropriately.

Implementation Plan and Timeline: Include why this objective was chosen, what you hope to change, how and when you will implement the strategy, and how you will evaluate its effectiveness.

Most mothers who return to work stop breastfeeding within 7 weeks of their return. We felt that this was the most likely place to assist with continuation of exclusive breastfeeding. Our IBCLC will hold her first "Business Case for Breastfeeding" program in June 2008. We will decide after that how often to hold them and who our audience needs to be at each one.

Two of our MOAs (clerks) are former Peer Counselors and having them up front being the first one to answer the phone for a mom requesting formula has been invaluable. We realized that our other two MOAs would also benefit from training

so they don't automatically give a can of formula when actually a referral to the IBCLC may be warranted. We will conduct at least 4 inservices in the next year (quarterly) to keep our MOAs up to date on breastfeeding information, how to handle the calls, and appropriate referral sources here at WIC and in the community.

EVALUATION OF WIC NUTRITION EDUCATION PLAN
FY 2007-2008

WIC Agency: Deschutes County

Person Completing Form: Laura Spaulding, RD

Date: April 14, 2008 Phone: 541-322-7450

Return this form, attached to email to: sara.e.sloan@state.or.us by May 1, 2008

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

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

Year 1 Objective: During plan period, staff will be able to correctly assess nutrition and dietary risks.

Activity 1: All certifiers will complete the Nutrition Risk Module by December 31, 2007.

Outcome evaluation: Please address the following questions in your response.

- Did all certifiers successfully complete all the activities of the Nutrition Risk Module by December 31, 2007?
- Were the completion dates entered into TWIST and the competency achievement checklist filed for each certifier?

Response:

Yes, all of the certifiers completed the Nutrition risk module. We did it in sections on the following dates: Workbooks 1-4 on August 23, 2007; Workbook 5 on August 30, 2007; Workbook 6 on September 6, 2007.

Yes, all of the completion dates were entered into TWIST and the competency checklists were filed.

Ongoing review: we play "Risiko" and do case studies, etc. at staff meetings.

Activity 2: All certifiers will complete the revised Dietary Risk Module by March 31, 2008.

Outcome evaluation: Please address the following questions in your response.

- Did all certifiers successfully complete all the activities of the Dietary Risk Module by March 31, 2008?
- Were the completion dates entered into TWIST and the competency achievement checklist filed for each certifier?

Response: Yes, all certifiers completed the Dietary Risk Module on October 18, 2007. Yes, all of the completion dates were entered into TWIST and the competency checklists were filed.

Activity 3: (this line wasn't here so I added it in)

Janet Harris, MS RD was part of the workgroup. They worked on:

- Survey feedback on Cooking Demo Kits 9/07
- Survey feedback on Nutrition Education Topics
- Survey feedback and testing of class – Fit Kids Class 10/07
- WIC Key Nutrition Messages – review and feedback – various dates

Activity 4: Identify your agency training supervisor(s) and staff in-service dates and topics for FY 2007-2008.

Outcome evaluation: Please address the following questions in your response.

- Did your agency conduct the staff in-services you identified?
- Were the objectives for each in-service met?
- How do your staff in-services address the core areas of the CPA Competency Model?

Response: Training Supervisors include Laura Spaulding, Janet Harris, Sherri Tobin. We did not conduct the inservices according to the timeline submitted per se. However, we did cover all of the topics throughout the year at staff meetings and at our Nutrition Education meetings and the objectives were met.

Motivational Interviewing: Julie Reeder and Katherine Wagner came down on a couple of occasions and did observations and provided feedback. We also set aside time at each staff meeting to review MI and offer suggestions, ask questions, etc.

Nutrition Risk Module Follow-up and Diet Assessment Module Follow-up: Wow, these both generated many conversations that one inservice never could have covered. Each module brought forth a lot of questions, concerns and “ah ha” moments from even

the most seasoned staff members. We reviewed questions, concerns and additional “parking lot” items for several months in the fall until we addressed all topics that came up.

VENA—due June 2008----we will continue to discuss how Motivational Interviewing meshes with the Oregon WIC Listens project and talk about how Deschutes County can help other counties get started. We have already had visitors from Malheur county come and observe clinic to get ideas about how to proceed.

Our staff inservices are directly related to the certifications we do. Our topics range from ideas sent by the state, to what is new in the news that our clients are talking about. Most of the time they are nutrition related but once in a while we may have one on immunizations, food stamps or other topics still related directly to our clients. Please see the attached “Nutrition Ed Meetings 07/08” document for the list of what we covered in the last year.

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

Year 1 Objective: During plan period, each agency will implement strategies to provide targeted, quality nutrition education.

Activity1: Using state provided resources, conduct a needs assessment of your community by September 30, 2007 to determine relevant health concerns and assure that your nutrition education activity offerings meet the needs of your WIC population.

Outcome evaluation: Please address the following questions in your response:

- Was the needs assessment of your community conducted?
- What health concerns did you determine were relevant to your community?
- What did you do with the information you collected?
- Who did you communicate the results of your needs assessment with?

Response: Yes, the needs assessment was conducted; the “concerns and risks” section outlines the health concerns. We focused on Elevated Weight Gain in pregnant women. We conducted Key Informant interviews anecdotally with clients and Maternal Child Health staff. Results are attached. We originally planned to showcase our results at the ACOG meeting in Sunriver on April 4-6th, however, we discovered that the \$750 booth fee was a little out of our range. So “Plan B” is to do a quick staff inservice at one of our local OB/Gyn groups who employs a nurse practitioner who happens to be very interested in the topic. We are hoping to do this by June, 2008. We are also going to

share our results with WIC staff and the MCH staff as well as our Healthy Start Team (provides low-cost prenatal care to uninsured women).

All supporting documents are attached.

Activity 2: Complete Activity 2A or 2B depending upon the type of second nutrition education activities your agency offers.

Activity 2A: By October 31, submit an Annual Group Nutrition Education schedule for 2008.

Activity 2B: If your agency does not offer group nutrition education activities, how do you determine 2nd individual nutrition education is appropriate to the clients' needs?

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

- If your agency offers group nutrition education, did you submit your Annual Group Nutrition Schedule for 2008?
- How do you assure that your nutrition education activities meet the needs of your WIC population?

Response: Please see attached Annual Group Nutrition Schedule for 2008. We develop objectives with key messages that we want the client to have. We also do class evaluations at the end of each session and adjust the classes according to the feedback as best we can.

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

Year 1 Objective: During plan period, each local agency will develop at least one specific objective and activity to help facilitate healthy behavior change for WIC staff and at least one specific objective and activity to help facilitate healthy behavior change for WIC clients.

Activity 1: Local Agency Objective to facilitate healthy behavior change for WIC staff. Local Agency Staff Activity.

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

- How did your agency decide on this objective and activity?
- Did the activity help meet your objective?
- What went well and what would you do differently?

Response: Stretch breaks during all 2 hour or more staff meetings, sometimes individual, sometimes group activities. Staff commented that they love this goal and want to continue it.

This objective was chosen because some WIC staff have difficulty finding time to exercise so this will demonstrate how to add it in during regular daily events. Some staff are uncomfortable sitting for long periods of time so this will offer a break. As stated in the Activity, we will offer a 10 minute walk break during each staff meeting (2nd and 4th Thursday of every month), Nutrition Education meeting (1st Thursday of every month), and any other WIC meeting scheduled to last longer than two hours (i.e. module training). At the end of each meeting, we will discuss with all staff present how they felt about taking a walking break, how it effected them physically and mentally, and if they want to continue at further meetings. The activity did meet our objectives. The biggest barrier was remembering to do it. With practice though we are learning to remind each other as the meeting mid-point rolls around.

The “Commute Options” activity actually rewarded healthy behavior by providing gift certificates for staff who engage in regular physical activity during their day. The hardest part about this was that it wasn’t feasible for everyone to participate and sometimes the funding source ran out of money so those who completed their journals didn’t get a prize.

Activity 2: Local Agency Objective to facilitate healthy behavior change for WIC clients. Local agency Client Activity.

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

- How did your agency decide on this objective and activity?
- Did the activity help meet your objective?
- What went well and what would you do differently?

Response: *See Food of the Month List of Topics
Links on Deschutes County WIC Website – What’s cooking to see examples.

<http://www.co.deschutes.or.us/go/objectid/FDB405A9-9027-D5E6-3D50C0CA4439DF99/index.cfm>

This objective was chosen because during our diet assessments we see a lot of the same foods on client diet sheet; also, clients are consistently asking us for “healthy recipes” so this will motivate us to research easy recipes to hand out. We hope to increase client’s diet variety. We will have recipes available for client use, bulletin boards showing properties of the food (how to choose, how to store, etc). Possibly food/recipe tasting at our 2nd NE classes. This project will run from July 2007 through June 2008. We will use anecdotal information from certifiers regarding client feedback to assess the effectiveness of this activity. (see attached list also)

The enthusiasm for this project was great at the beginning. Everyone wanted to contribute because we all had seen the same foods on all of the diet recalls for so long; and, everyone that contributed picked a fruit or vegetable, made a handout, had sample recipes at classes, etc. However, as you can see from the attachment, interest faded and soon no one was signing up. Was it the demise of the food recalls so no one was seeing the same diet ruts over and over? Was it acknowledgement of how Motivational Interviewing is changing how we give out handouts? We aren’t sure exactly. We do know that eventually we will finish out the year’s worth of foods so we can have some fall-back themes for our Quick WIC classes and also so we can have a complete year on the website.

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

Year 1 Objective: During plan period, each local agency will develop at least one objective and activity to help improve breastfeeding outcomes for WIC staff or WIC clients.

Activity 1: Local Agency Breastfeeding Objective. Local agency Breastfeeding Activity.

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

- How did your agency decide on this objective and activity?
- Did the activity help meet your objective?
- What went well and what would you do differently?

Response: This objective was chosen because we have found that many mothers give up on breastfeeding in the first two weeks after birth. We are hoping that with additional support, more mothers will feel that they can be successful. Our lactation nurse is currently calling clients within three days of them reporting the birth of their child. We have had especially good continuity of care since our lactation nurse also provides on-call

lactation services at the hospital where the majority of our Bend clients deliver. The TWIST reports are difficult to extrapolate information from so we are not using these as our guide. Our clients report good support, get their questions answered and feel that they have options for continuing breastfeeding so we feel our objective is being met. The nurse will continue to make the calls and offer support; we are not planning to do anything differently at this time.

Nutrition Ed Meetings 07/08

Date	Topic	Objective	Comments
June 7, 2007	06/07 NE Plan Evaluation 07/08 NE Plan Goals	NE Staff will be updated on the progress made on the 06/07 NE Plan and will be informed of our goals for 07/08	Janet
July 19, 2007	WHO Formula Preparation Guidelines and WHO Growth Grids for Breastfed Infants	NE Staff will be aware of the WHO Formula Preparation Guidelines and the differences between the CDC growth grids and the WHO growth grids	Sherri
August 23, 2007	Nutrition Risk Module	See goal	Janet, Sherri and Laura
September 6, 2007	Kristina Johnson – Immunization Review	NE Staff will have adequate knowledge and resources to screen WIC clients immunization records and do appropriate referrals	Kristina Johnson
October 4, 2007	Food Safety for Moms to Be – Preview Video	NE Staff will have accurate and up to date information on Food Safety for Pregnant Women	Janet/Video
November 1, 2007	Nutrition Risk Prevalence Data	NE Staff will review will be aware of the top 5 risk factors for Deschutes County WIC – Bend, Redmond and LaPine and have a chance to strategize appropriate actions to take	Janet
December 6, 2007	Calcium Recs and Lactose Intolerance	NE Staff will be able to help parents select approp foods to meet calcium recommedations	Janet

		depending on age and status (WP, WB)	
	Slow Weight Gain Risk Code	NE staff will be able to correctly assess and assign Risk Code 135	Janet
	ADA Journal Review – Food Stamp Cycle	NE Staff will be aware of recent research related to the Food Stamp Cycle and how it can impact WIC clients	Janet
January 3, 2008	Nutrition Risk Module – “Risko”	NE Staff will review Nutrition Risks	Janet
	ADA Journal Review –Dec,07 Who Can Afford to Eat Right?	NE Staff will be aware how the cost of foods are changing and how it these changes impact WIC Clients	Janet
February 7, 2008	Tofu Safety	NE Staff will give accurate information regarding Tofu safety for WIC clients. NE Staff will update any NE written information that has tofu on it	Sherri
March 6, 2008	Healthy Fats h/o	NE Staff will review different types of fats and their uses. NE staff will be familiar with uses for the new handout created	Sherri
	Nutrition Risk Module Updates	NE Staff will be informed of the changes made to the Nutrition Risk Module	Sherri

WIC Workshops Deschutes County 2008

Workshop.....	Topic	Abbr	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Bkfast for Busy Fam+	GN	BFBF												
Breastfeeding	BF	BF	X _L	X _R	X	X _{R,L}	X	X _R	X _L	X _R	X	X _{R,L}	X	X _R
Back to Work	BF	BTW	X	X	X	X	X	X	X	X	X	X	X	X
Mother's Café*	BF	BFC	X	X	X	X	X	X	X	X	X	X	X	X
Baby Let's Eat	IF	BLE	X	X	X	X	X	X	X	X	X	X	X	X
Baby Signs for Mealtim	PH	BS	X		X		X		X		X		X	
Cooking with Beans+	GN	CWB												
Cooking with Herbs+	GN	CWH												
Cooking with Squash+	GN	CWS												
Dental Screening*	PH	HT	X	X	X	X	X	X	X	X	X	X	X	X
Farmers Market*	FM	FM						X _{R,L}	X _{R,L}	X _{R,L}				
Fit Kids/Fit Families*	CN	FK	X		X		X _R		X		X		X _R	
Happy Home Meals*	GN	HHM												
Healthy Mex Cooking*	GN	HMC												
Health/Nutr Busy Mom	PP	HNBM		X			X			X			X	
Infant Massage	PH	IM		X		X		X		X		X		X
Kid's Club	GN	KC		X		^R		X				X _R		
No Battle, Better Eat*	FR	NBBE			^(R)	X				X	^(R)			X
Prenatal Nutr and Fit*	PN	PNF	X	X	X	X	X	X	X	X	X	X	X	X
Quick and Easy Meals+	GN	QEM												
Quick WIC*	GN	QUI	X _{R,L}											
Story Time for Kids*	GN	STK				X				X				X
Stretch Your Food \$*	GN	SF\$	^(R)	X				X _R				X		

* = Offered in Spanish + = Quick WIC Topics R = Redmond L = LaPine

Food of the Month Schedule

Month	Who	What	Notes
July 2007	Janet	Nectarines	
Aug 2007	Grace	Zucchini	
Sept 2007	Sherri	Apples	
Oct 2007	Karina	Sweet Potatoes	
Nov 2007	Jean	Cranberries	
Dec 2007	Susan	Pumpkin	
Jan 2008	Erin	Oranges	
Febr 2008	Janet	Spinach	
Mar 2008			
Apr 2008			
May 2008			
June 2008			

Key Informant Interviews:
MCH Staff

1. What do your client's tell you they are hearing about recommendations for weight gain during their pregnancy?
2. How do you feel your clients like to be talked to about their weight gain?
3. How often do your client's OBs talk to them about their weight gain?
4. What interventions do you feel would be most effective in helping your clients gain the right amount of weight during their pregnancy?
5. What interventions do you feel would be most effective in helping your clients achieve and maintain a healthy weight postpartum?

Key Informant Interviews:
Clients

1. What have you heard about how much weight you should gain during your pregnancy?
2. How often does your prenatal provider talk to you about your weight gain?
3. How do you like health professionals to talk to you about your weight gain?
4. What would help you the most to gain the right amount of weight during your pregnancy?
5. What would help you the most to achieve and maintain a healthy weight after having your baby?

Key Informant Interviews:

Clients: 2/21/08, 3/13/08, 3/20/08, 4/03/08 Prenatal Nutrition and Fitness

English and Spanish

14 clients, 5 guests (3 partners, 1 mom and a friend);all in 2nd and 3rd Trimester

1. What have you heard about how much weight you should gain during your pregnancy?

- 20 to 30 pounds
- 25 to 30 pounds x 5
- 25 pounds
- 1 pound per week
- Don't pay attention
- Depends on where your weight was to begin with
- 38 pounds
- Nothing
- I should slow down, I'm gaining too fast
- I was overweight before pregnancy and should not gain that much

2. How often does your prenatal provider talk to you about your weight gain?

- I've only had 2 appointments, she hasn't talked to me at all. x 2
- Got chewed out because I gained a lot of weight, I'm not concerned, had my hiking boots on and heavy clothes, I'm eating healthy and staying active, I don't look like I've gained too much. I have a BS degree and know what I should eat.
- Not much at all, she just keeps track of it, she writes it down
- At every visit x 3
- I asked her, she said I had only gained 13# and that I should gain 13 more pounds
- Hasn't talked to me at all, just says "I'm fine"
- I don't think he's ever talked to me about it

3. How do you like health professionals to talk to you about your weight gain?

- I would like her to talk to me
- Let me know what I've gained
- I like it the way she does it; if there were concerns, she would tell me, I trust her
- I wouldn't mind, I weigh myself at home, let me know
- I just want to know if I'm gaining what I'm supposed to be gaining
- Don't say "well what are you doing?"
- I'd like to know how much I should gain
- I'm fine with my weight
- Why does it matter?
- I gained a lot of weight with my previous and don't want to gain as much
- Be straight-forward and up front x 3
- Be positive, give me positive affirmation, even if I need to work on it
- Be specific, mention a specific thing that I can do to slow down.

4. What would help you the most to gain the right amount of weight during your pregnancy?

- Knowing the right things to eat, portions and how much exercise x 8
- Websites – babyfit.com
- Learning why weight is important
- How to not gain so fast
- Having goals, make it a game
- Do specific exercises, make it attainable

5. What would help you the most to achieve and maintain a healthy weight after having your baby?

- Exercise
- Workout during the pregnancy
- Eating healthy
- Know places where to exercise
- Getting used to different foods
- Support from other moms and friends
- Help from family – like husband, does not want to change the way we eat
- Finding time
- Play groups
- Nursing x 2
- Include your baby, make it a routine
- Involving your baby, stroller or yoga with baby

6. Other comments?

- Most women stated that their nurse reviewed rec weight gain with them at their 1st appointment.
- Most women stated that their OBs rarely talked to them about their weight.
- One woman was clearly very defensive about this topic because of the way she was “chewed out” about a jump in her weight.

Key Informant Interviews: MCH Staff
3/18/08 Staff Meeting
(7 Nurses)

1. What do your client's tell you they are hearing about recommendations for weight gain during their pregnancy?
 - Answers ranged from "nothing" to "they know how much they should gain"

2. How do you feel your clients like to be talked to about their weight gain?
 - I focus on nutrition, especially if history of an Eating Disorder
 - I like to show them a visual, explain the graph
 - I had one overweight woman tell me she was "yelled at" by someone in WIC

3. How often do your client's OBs talk to them about their weight gain?
 - Only if there is a problem.
 - Rarely

4. What interventions do you feel would be most effective in helping your clients gain the right amount of weight during their pregnancy?
 - Visuals, education, being specific, portion sizes

5. What interventions do you feel would be most effective in helping your clients achieve and maintain a healthy weight postpartum?
 - Visuals, education, being specific, portion sizes, exercise classes at the Health Department, strollers for our moms

6. Other comments:

My interviews w/MCH staff were more challenging. It was hard for them to give me answers from their client's perspective because they have so much passion for helping the women that they see. They are passionate that our clients need more education and skills that would help them eat healthier and gain the right amount of weight. They are going to order a few copies of the video that we use in our Prenatal Nutrition and Fitness Class to have available for MCM visits.

Attachment A

FY 2008-2009 WIC Nutrition Education Plan

Goal 1, Activity 3

WIC Staff Training Plan – 7/1/2008 through 6/30/2009

Agency: Deschutes County

Training Supervisor(s) and Credentials: Janet Harris, MS, RD; Sherri Tobin, MS, RD, IBCLC; Laura Spaulding, RD

Staff Development Planned

Based on planned new program initiatives (for example Oregon WIC Listens, new WIC food packages), your program goals, or identified staff needs, what quarterly in-services and or continuing education are planned for existing staff? List the in-services and an objective for quarterly in-services that you plan for July 1, 2008 – June 30, 2009. State provided in-services, trainings and meetings can be included as appropriate.

Quarter	Month	In-Service Topic	In-Service Objective
1	July-Sept	Review of new Oregon WIC Key Nutrition Messages	Staff will be familiar with the Oregon WIC Key Nutrition Messages and be able to identify which ones they need additional training on.
2	October-Dec	Changing NE messages based on new food packages	Staff will understand rationale behind food package changes and be able to adjust their NE messages accordingly.
3	January-March	Mid-year evaluation of staff physical activity objective	Staff will evaluate how changing templates & PA Toolkit are working and make suggestions for change if needed.
4	April-June	State training on new food packages (cohort 4)	State will decide on objectives

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Attachment A

FY 2008-2009 WIC Nutrition Education Plan

Goal 1, Activity 3

WIC Staff Training Plan – 7/1/2008 through 6/30/2009

Agency: Deschutes County

Training Supervisor(s) and Credentials: Janet Harris, MS, RD; Sherri Tobin, MS, RD, IBCLC; Laura Spaulding, RD

Staff Development Planned

Based on planned new program initiatives (for example Oregon WIC Listens, new WIC food packages), your program goals, or identified staff needs, what quarterly in-services and or continuing education are planned for existing staff? List the in-services and an objective for quarterly in-services that you plan for July 1, 2008 – June 30, 2009. State provided in-services, trainings and meetings can be included as appropriate.

Quarter	Month	In-Service Topic	In-Service Objective
1	July-Sept	Review of new Oregon WIC Key Nutrition Messages	Staff will be familiar with the Oregon WIC Key Nutrition Messages and be able to identify which ones they need additional training on.
2	October-Dec	Changing NE messages based on new food packages	Staff will understand rationale behind food package changes and be able to adjust their NE messages accordingly.
3	January-March	Mid-year evaluation of staff physical activity objective	Staff will evaluate how changing templates & PA Toolkit are working and make suggestions for change if needed.
4	April-June	State training on new food packages (cohort 4)	State will decide on objectives

DESCHUTES COUNTY HEALTH REPORT

2007



The Deschutes County Health Department
presents this report to the residents of Deschutes County so they may be
better informed about the health issues and behaviors that affect their lives.

INTRODUCTION

The Deschutes County Health Department is pleased to present the *Deschutes County Health Report*, a compilation of key health indicators for our county. The goal of this report is to provide health data that can be used by local government and community agencies, health care providers, and other interested community members and groups to help identify and better address the health needs of Deschutes County.

The health indicators examined in this report are used to represent trends by tracking measurable changes over time. As much as possible we use established national and statewide goals, such as the U.S. Surgeon General’s Healthy People 2010 objectives and the Oregon Progress Board’s 2005 benchmarks, to gauge our progress. Our concept of health is broad, as indicated by the inclusion of data regarding issues such as poverty, homelessness, and violent injury.

The *Deschutes County Health Report* identifies several important areas where the County meets national health objectives or has improved over the last several years. Some examples are:

- First trimester prenatal care – Deschutes County has

consistently ranked among the highest in Oregon.

- Teen pregnancy rates – dropping to an all time low in Deschutes County.
- Breastfeeding initiation – Oregon’s Women, Infants, and Children (WIC) program ranks first in the nation for breastfeeding initiation. The Deschutes County WIC initiation rate is even higher.

The report also points to areas where significant work still needs to be done. Examples are:

- Rising obesity rates, especially in children
- Immunization rates far below the state average
- Alcohol, tobacco, and other drug use among adolescents
- High percentage of residents without health care coverage
- Lack of fluoridated water supplies to prevent tooth decay and improve oral health

It is our hope that the information provided by this report will motivate local government, community agencies, and citizens to collaboratively address the growing health needs across our county. By improving the health of our residents, we strengthen the community as a whole.

NOTE ON DATA AND BENCHMARKS

(Healthy People 2010 Objectives and Oregon 2005 Benchmarks)

This report relies exclusively on secondary data, i.e. data collected by other organizations, and utilizes the most current data available from these sources. Healthy People 2010 objectives and Oregon 2005 Benchmarks are given in relation to Deschutes County data when available and appropriate. Healthy People 2010 is a federal initiative which sets national disease prevention and health promotion objectives to be achieved by the end of this decade. Oregon Benchmarks are set by the Oregon Progress Board as statewide objectives.

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DEMOGRAPHICS

Deschutes County Population by Age, 2006

	0-17 years	18-64 years	65+ years
	34,381	98,246	19,988
total %	(22.5%)	(64.4%)	(13.1%)

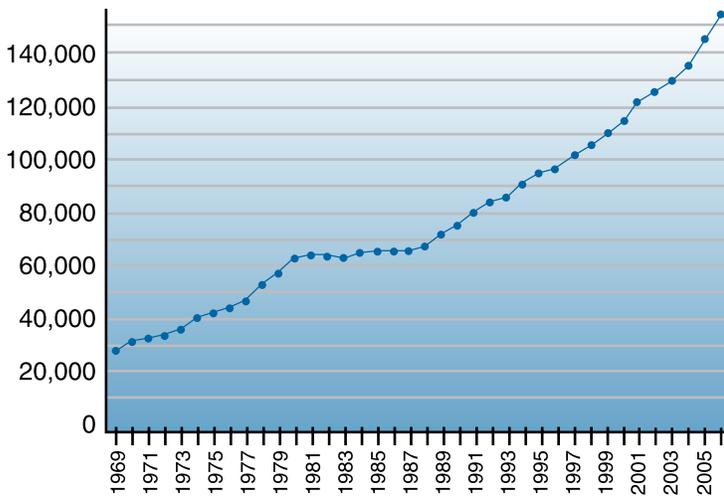
Source: Portland State University-Population Research Center, 2006 Age Estimates

Oregon Population by Age, 2006

	0-17 years	18-64 years	65+ years
	872,280	2,356,686	461,539
total %	(23.6%)	(63.9%)	(12.5%)

Source: Portland State University-Population Research Center, 2006 Age Estimates

Deschutes County Population 1969-2006



Population of Deschutes County, 2006: 152,615. Deschutes County continues to be the fastest growing county in Oregon, with a 32.3% increase in population from April 2000 - July 2006.

Source: Portland State University-Population Research Center, 2005 Oregon Population Report and 2006 Preliminary Population Estimates.

Education Level - 2005*

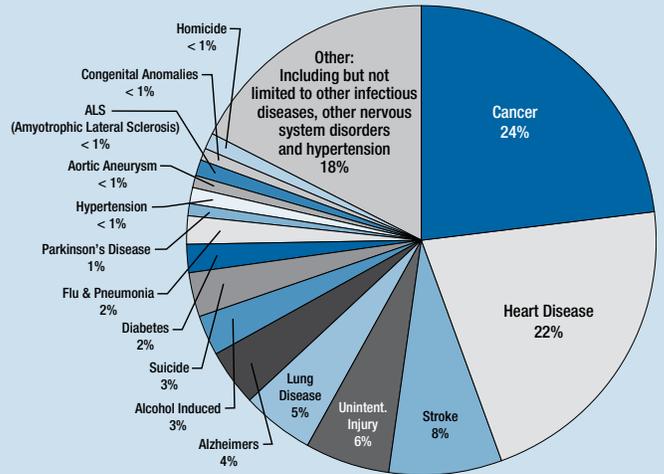
	Deschutes County	Oregon	United States
Less than HS degree	12%	13%	16%
HS Graduate	22%	26%	30%
Some College, no Degree	28%	26%	20%
Associate Degree	9%	7%	7%
Bachelor Degree	21%	18%	18%
Graduate or Professional Degree	8%	10%	10%

* Numbers may not add up to 100% due to rounding.

Source: U.S. Census, 2005 American Community Survey

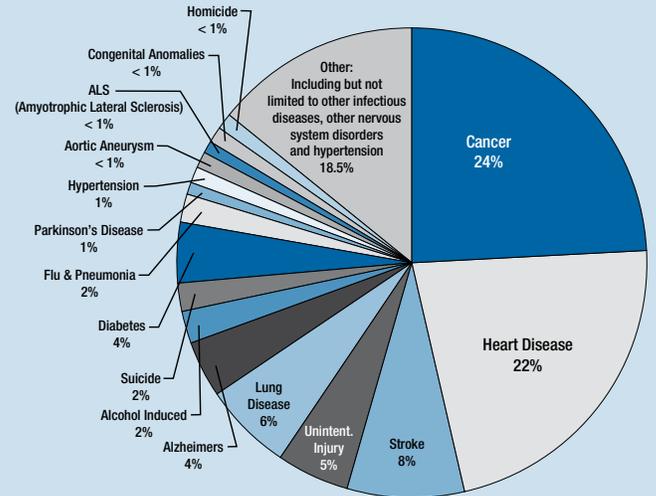
Leading Causes of Death Deschutes County, 2004

Source: DHS/Center for Health Statistics



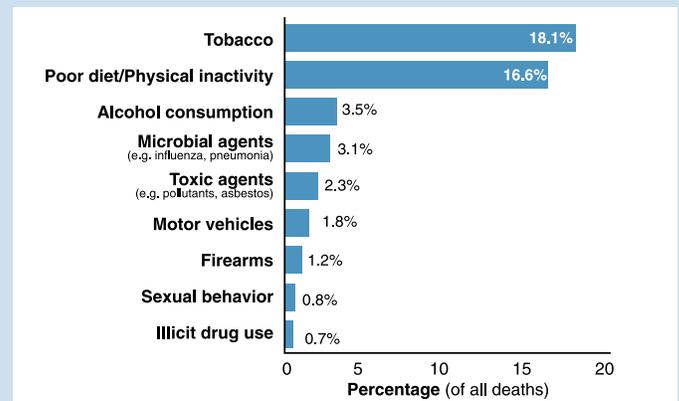
Leading Causes of Death Oregon, 2004

Source: DHS/Center for Health Statistics



Actual Causes Associated with Death United States, 2000*

Behavioral and lifestyle choices such as smoking, poor nutrition, and physical inactivity are major contributors to the leading killers, which include heart disease, cancer and stroke. It is anticipated that the consequences of physical inactivity and poor nutrition will soon overtake tobacco as the leading cause of death in the United States.



*Most current analysis of actual causes of death.

Source: Mokdad et al., Journal of the American Medical Association, March 10, 2004 - Vol 291, No. 10.

Births & Deaths, Deschutes County, 2000-2005

	2000	2001	2002	2003	2004	2005
Births	1,438	1,480	1,487	1,575	1,663	1,783
Birth Rate	12.3	12.1	11.8	12.1	12.3	12.4
Deaths	916	957	973	997	961	N/A*
Death Rate	7.9	7.8	7.7	7.6	7.1	N/A*

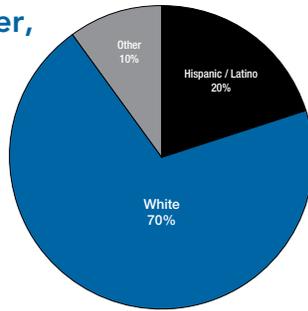
*N/A = Not Available
Source: DHS / Center for Health Statistics

Emerging Access Needs

While only 5.2% of the Deschutes County population in 2005 was made up of Hispanics, 12% of births in 2005 were to Hispanic mothers. As the Hispanic and other minority populations continue to grow in Deschutes County, we must work to reduce cultural and linguistic barriers that prevent equal access to public information and community services.

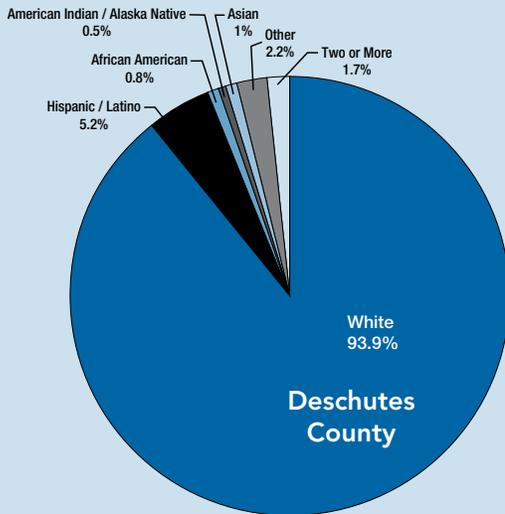
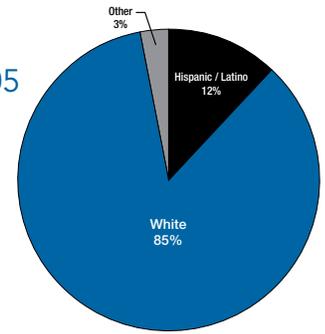
Race / Ethnicity of Mother, Oregon Births, 2005

Source: DHS / Center for Health Statistics



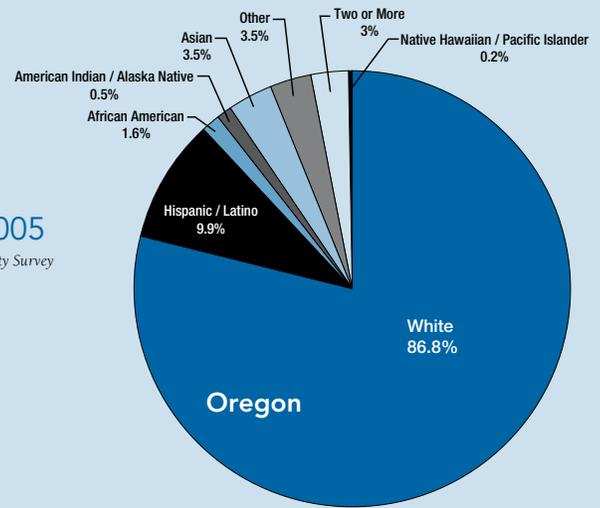
Race / Ethnicity of Mother, Deschutes County Births, 2005

Source: DHS / Center for Health Statistics



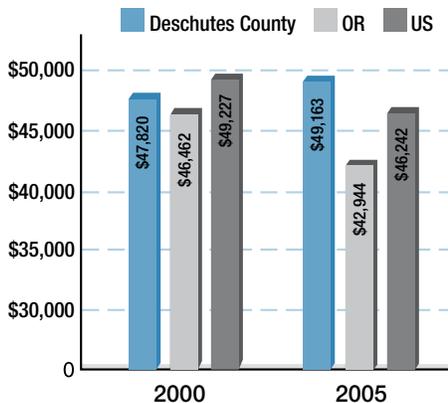
Race / Ethnicity, 2005

Source: U.S. Census, 2005 American Community Survey



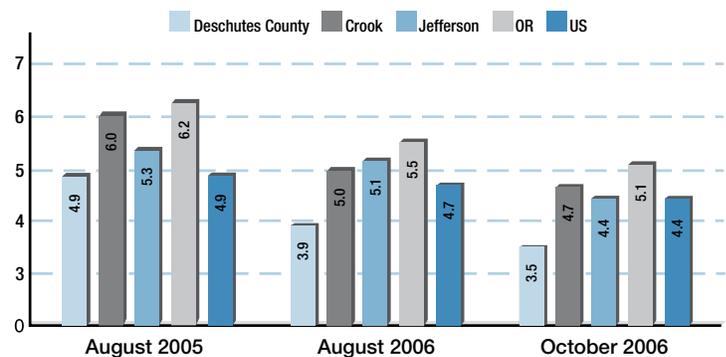
ECONOMY

Median Household Income



Source: U.S. Census, 2005 American Community Survey

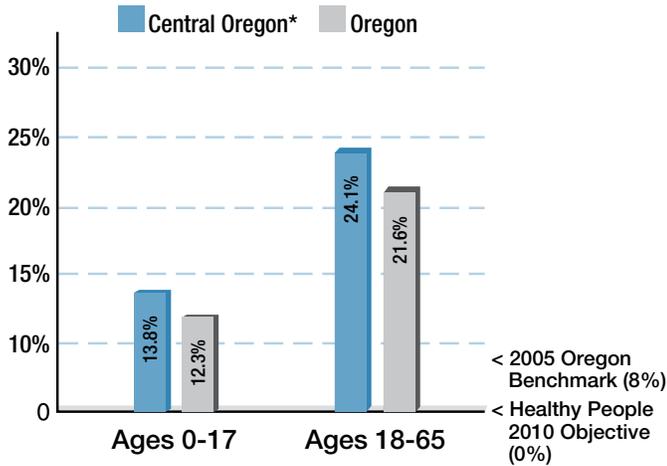
Unemployment Rates



Source: U.S. Census, 2005 American Community Survey; Oregon Employment Department

ACCESS TO HEALTH CARE

Uninsured:
Individuals with No Health Insurance, 2004

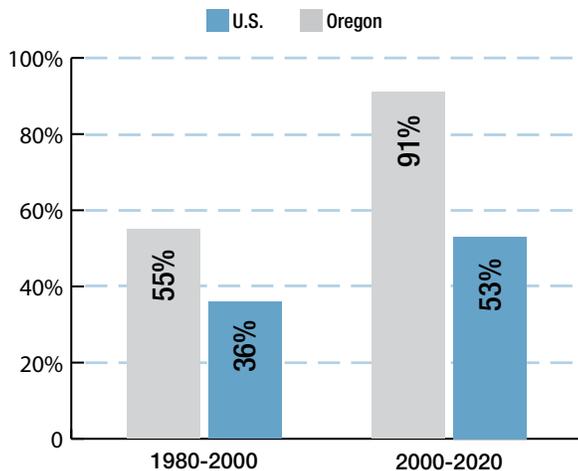


*Combined regional estimates for Crook, Deschutes and Jefferson counties.
Source: Oregon Population Survey, 2004

The percentage of uninsured Central Oregonians shown above equals approximately **32,450 people**. Of those, **6,120 are children** under the age of 18 years.

The consequences of high uninsured rates can be devastating. The Kaiser Commission on Medicaid and the Uninsured conducted a thorough review of the past 25 years of health services research on the effects of health insurance coverage. The results demonstrated that the uninsured receive less preventive care, are diagnosed at more advanced stages, and once diagnosed, tend to receive less therapeutic care such as drugs and surgical interventions.

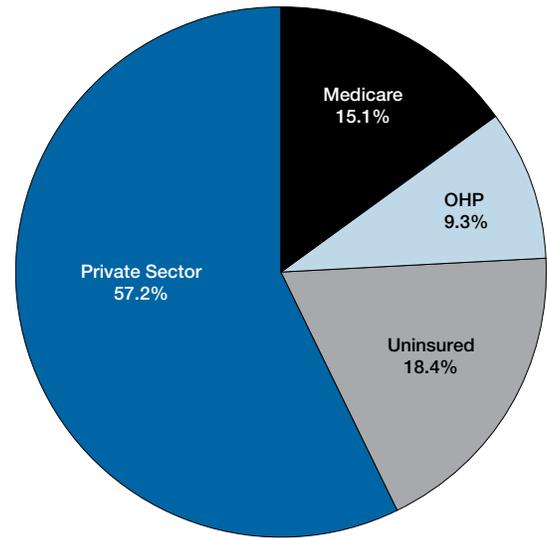
MEDICARE
Projected Change in Oregon & U.S. Population
65+ Years of Age



If population projections hold true, the increase in residents 65+ years of age in Deschutes County will be significant. There is serious reason to be concerned about where these people will receive care.

Source: Health Resources and Services Administration

Central Oregon Population
by Source of Coverage*



*Note: OHP data is from 6/06. The most current Medicare, private sector and uninsured data is from 2003 and 2004.
Source: Oregon Population Survey, 2004

Consequences of High Uninsured and Medicaid Rates:

The “cost-shifting” cycle. This refers to the shifting of people and costs between segments of the health care market. When Medicare and Medicaid reimbursements fail to cover the full cost of providing care, there is a “cost shift” to private payers to make up the difference. The increasing costs are passed along to employers and consumers in the form of higher premiums, which changes the market and makes health coverage less affordable.

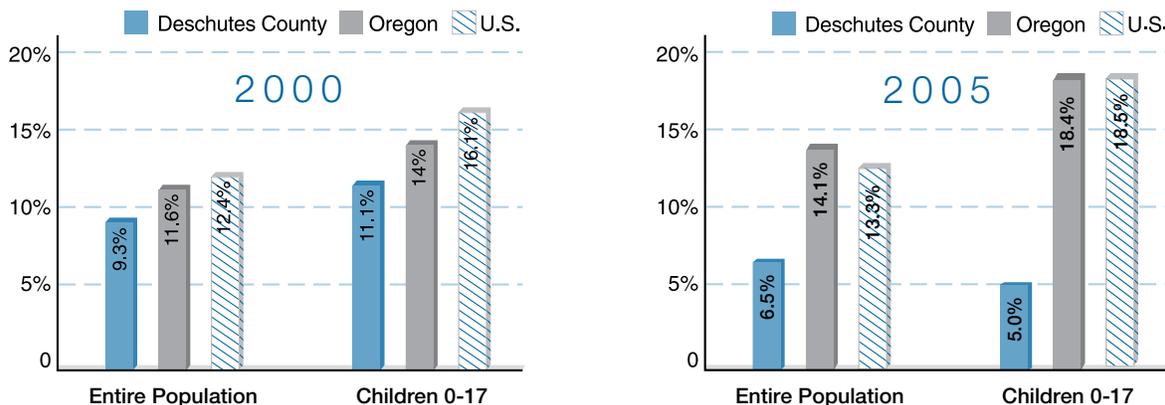
MEDICAID

Oregon Health Plan Enrollees, December 2006

As of December, 2006 there were 11,490 Oregon Health Plan enrollees in Deschutes County. Of those, 436 people were enrolled in the OHP Standard plan, which makes them “open card” patients. While they are permitted to seek care from any provider, there is no requirement that providers accept them as patients. The result has been an inability for many with OHP Standard coverage to access care and establish a medical home.

POVERTY, HUNGER & HOMELESSNESS

Poverty: Individuals Living in Poverty, 2000 vs 2005



In Deschutes County, a total of 9,072 individuals, including 1,522 children, were living in poverty in 2005.

Source: U.S. Census Bureau, American Community Survey, 2005

HOMELESSNESS

Tri-County Homeless Count, 7.26.06

- 1344 individuals
- 727 adults (54%)
- 617 were children under the age of 18 (46%)
 - 154 were under the age of 6 years

On January 26, 2006, the Homeless Leadership Council, with the help of 50+ volunteers, conducted a count of homeless residents living in Deschutes, Jefferson and Crook counties. The primary self-reported reason for homelessness was economic hardship as 44% reported that they were homeless because they could not afford rent. Only 365 people (27%) had access to some form of shelter by a local housing provider. The remaining 979 (73%) were living with family or friends, living outdoors or in cars, or staying in motel rooms. Currently, there are only 195 emergency shelter beds and 145 transitional housing beds available in the region.

Source: NeighborImpact

Homeless Students, 2005/06 School Year

A total of 534 homeless students were identified in Deschutes County during the 2005/06 school year. Statewide, 13,159 homeless students were identified. These numbers are thought to be a significant undercount as many students, especially at the high school level, do not want it known that they are homeless.

Source: Bend/La Pine School District; Redmond School District; Sisters School District; Oregon Department of Education.

- Unexpected events, such as paying for an emergency visit to the hospital or a car repair, can quickly force families into poverty.

- In 2005, there was a monthly average of 13,712 participants in Deschutes County's Food Stamp Program

Source: Neighborhood Impact

- During the 2005-06 school year, 33.7% of students in Deschutes County public schools were approved for Free and Reduced Lunch Programs.

Source: Oregon Department of Education

HUNGER

Oregon's national hunger ranking has dropped from #1 in 2002 to #17 in 2004, according to the United States Department of Agriculture. The change is thought to be the result of improved food stamp outreach and increased funding for and use of emergency food. While access to food has improved, it is important to note that the poverty still exists, and many families are often forced to choose between food and other expenses.

Food Bank Programs, 2005

While the Deschutes County population increased by 24% from 2000-2005, the number of people accessing food bank programs each month increased by 45%. This increase may be a reflection of the rising cost of living coupled with local wages that have not kept pace with housing and energy costs.

- Monthly average of individuals receiving food through emergency food bank programs in Deschutes County: 4998

Source: NeighborImpact

ADULT CHRONIC DISEASE

Many factors contribute to developing chronic disease. Many of these factors are lifestyle behaviors that can be modified. By altering behaviors, we can reduce the risk of developing heart disease, stroke, cancer, diabetes, lung disease and arthritis. For people diagnosed with chronic conditions, good disease management, including changes in nutrition and physical activity, dramatically reduces the risk of complications.

Communities, schools, worksites and health care sites can support and promote healthy behaviors through policies and environments like smoke-free worksites, healthy cafeteria meals, sidewalks and bike paths, incentives for bicycle and pedestrian commuters, worksite health promotion programs, and insurance coverage for preventive services such as mammography and tobacco cessation.

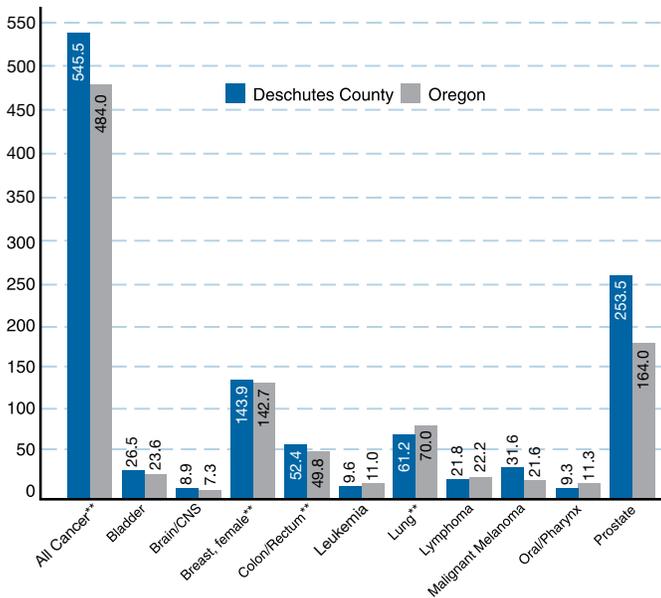
Cancer Cases and Deaths Deschutes County, 1999-2003

Type of Cancer	Number of Malignant Cases	Number of Deaths	Mortality to Incidence Ratio*
All Cancers	707	232	.39
Bladder	38	5	.13
Brain / CNS	11	8	.73
Breast, female	98	17	.17
Colon / Rectum	67	21	.31
Leukemia	11	8	.73
Lung	80	64	.80
Lymphoma	30	10	.33
Malignant Melanoma	44	6	.14
Oral / Pharynx	12	3	.25
Prostate	159	11	.07

*Mortality to Incidence Ratio (M/I) provides a measure of disease severity. The closer a M/I value is to 1.0, the poorer the expected outcome for a patient with cancer of that type.

Source: DHS-Oregon Cancer Registry (OSCaR) / Cancer in Oregon, 2003

Rates* of Cancer Cases, 1996-2003



* Age Adjusted Rates per 100,000 **Data range is 1999-2003

Source: DHS-Oregon Cancer Registry (OSCaR), 2004

Cardiovascular Disease

	Deschutes County	Oregon	Healthy People 2010 Objective
Coronary heart disease	4.3%*	3.8%*	
Heart attack	3.9%*	3.6%*	
Stroke	2.1%*	2.6%**	
Heart disease death rate	161.42***	179.23**	166
Stroke death rate	60.15***	61.94**	48

* Behavioral Risk Factor Surveillance System, 2002-2005 combined dataset

** Behavioral Risk Factor Surveillance System, 2005

*** Age-Adjusted death rate per 100,000 population - Oregon Death Certificates, 2004

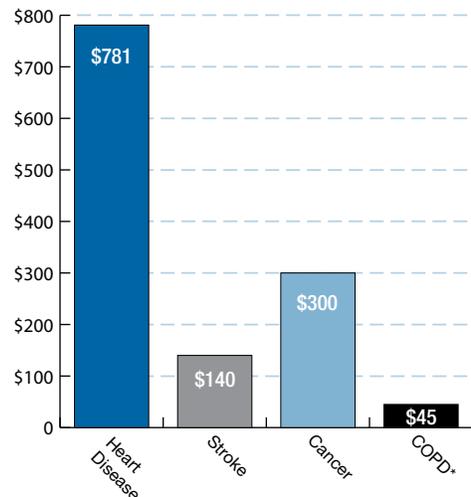
Cardiovascular disease (CVD) includes coronary heart disease, atherosclerosis, stroke and high blood pressure. It is the number one cause of death and disability in the United States and in Oregon.

Source: DHS-Oregon Heart Disease and Stroke Prevention Program

The Economic Impact of Cardiovascular Disease

There were over 40,000 hospitalizations of Oregonians for cardiovascular disease in 2004 (State Hospital Discharge Index), resulting in more than \$1.1 billion in hospital costs for heart disease, stroke, and related diseases. Cardiovascular disease-related hospitalizations greatly exceeded the costs of other chronic disease-related causes of hospitalization (see graph below). It is important to recognize that hospitalization costs reflect only a portion of the full financial burden of cardiovascular disease. Other expenditures include medications, rehabilitation, outpatient care, long-term care, and loss of productivity.

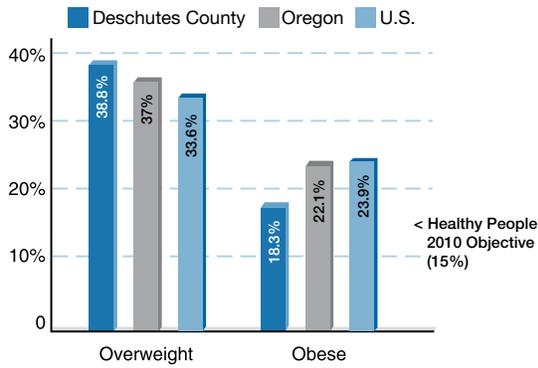
Hospitalization Costs by Principal Diagnosis, 2004



*Chronic obstructive pulmonary disease

Source: DHS/Heart Disease and Stroke Prevention Program, Oregon Heart Disease and Stroke Report, 2006; Oregon Hospital Discharge Index

Overweight and Obesity* among Adults, 2005



*In adults, obesity is defined as a Body Mass Index (BMI) of 30 kg/m² or more; overweight is a BMI of 25 kg/m² or more. BMI is calculated as weight in kilograms (kg) divided by the square of height in meters (m²).

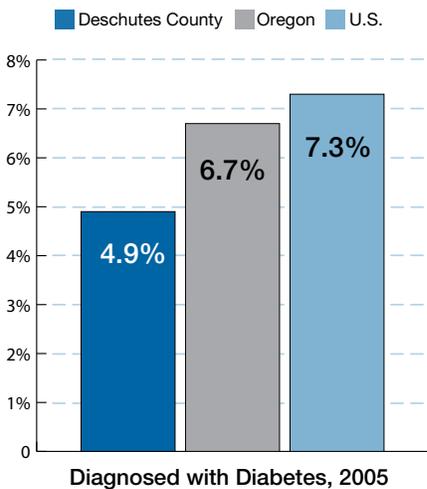
Overweight and obesity are major contributors to many preventable causes of death. Being overweight or obese substantially raises the risk of illness from high blood pressure, high cholesterol, type 2 diabetes, heart disease and stroke, gallbladder disease, arthritis, sleep disturbances and problems breathing, and certain types of cancers.

Source: Centers for Disease Control and Prevention. State-Specific Prevalence of Obesity among Adults - United States, 2005. MMWR September 15, 2006; 55 (No. 36); Behavior Risk Factor Surveillance System

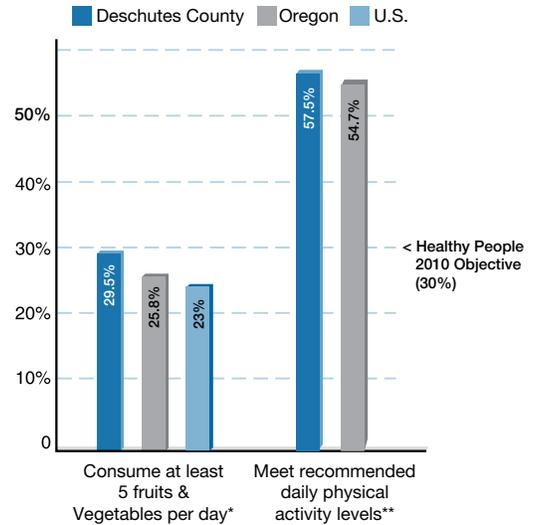
Diabetes

Diabetes can lead to serious complications and premature death, but people with diabetes can take steps to control the disease and lower the risk of complications. Type 2 diabetes accounts for about 90 percent to 95 percent of all diagnosed cases of diabetes. Many people with type 2 diabetes can control their blood glucose by following a healthy meal plan and exercise program, losing excess weight, and taking oral medication. Risks for the development of type 2 diabetes include older age, obesity, a family history of diabetes, a history of gestational diabetes, impaired glucose metabolism, physical inactivity, and race/ethnicity. Recent studies suggest that type 2 diabetes in children and adolescents, although still rare, is being diagnosed more frequently. This trend is thought to be tied to rising obesity rates in children and adolescents.

Source: Behavior Risk Factor Surveillance System; DHS/Oregon Asthma Program; Centers for Disease Control and Prevention



Nutrition and Physical Activity in Adults, 2002-2005



* U.S. percentage is from 2005 only

** moderate-intensity physical activity for 30+ minutes per day

Source: Behavior Risk Factor Surveillance System; DHS/Health Promotion and Chronic Disease Prevention Program

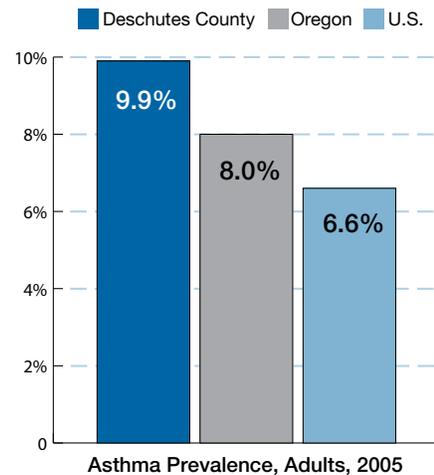
Chronic diseases are heavily impacted by poor nutrition and lack of physical activity. Deschutes County falls far short of the Healthy People 2010 objective for improved nutrition which calls for 75% of the population to consume the minimum servings of fruits (two daily servings) and 50% to consume the minimum servings of vegetables (three daily servings with at least 1/3 being dark green/deep-yellow). However, the County exceeds Healthy People 2010 objective for daily physical activity levels.

Source: Behavior Risk Factor Surveillance System; DHS/Health Promotion and Chronic Disease Prevention Program.

Asthma

Asthma is a lung disease that can be chronic and life threatening. Triggers include viruses, allergies, tobacco smoke, and gases and particles in the air. Limiting exposure to asthma or allergy triggers can often control asthma.

Source: DHS/Oregon Asthma Program; Behavioral Risk Factor Surveillance System, 2005



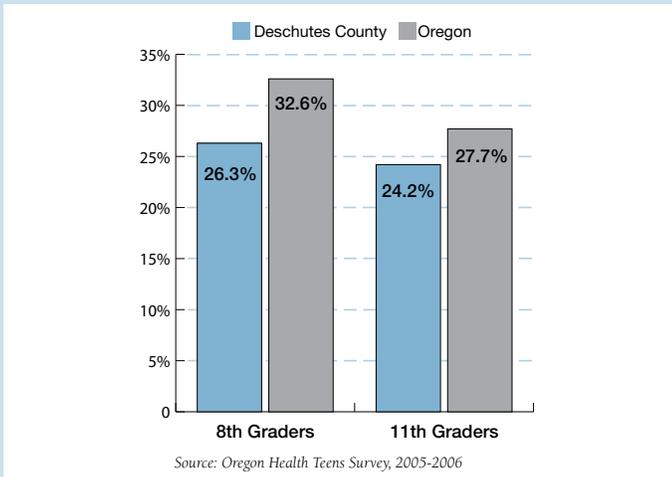
ORAL HEALTH

Although tooth decay is largely preventable, it remains the most common chronic disease of children age 5 to 17 years—5 times more common than asthma. Untreated decay can lead to infection, pain, and the loss of teeth. Poor children have nearly 12 times more restricted-activity days because of dental-related illness than children from higher-income families. Pain and suffering due to untreated tooth decay can

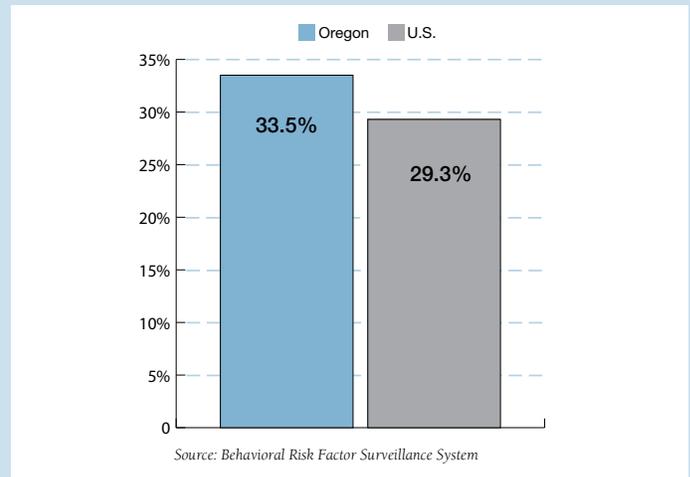
lead to problems in eating, speaking, and learning. Many adults also have untreated tooth decay: In the U.S., 27% of those 35 to 44 years old and 30% of those 65 years and older. Emerging evidence points to a strong link between oral diseases and many medical conditions and poor health outcomes.

Source: Centers for Disease Control and Prevention, Preventing Dental Caries

No dental visit within past 12 months, 2005-2006



No dental visit within past 12 months, Adults, 2004



Fluoridated Water

Fluoridation of community water is the single most effective public health measure to prevent tooth decay and improve oral health over a lifetime. More than 50 years of scientific research has found that people living in communities with fluoridated water have healthier teeth and fewer cavities than those living where the water is not fluoridated. While many communities have naturally occurring fluoride at levels sufficient to prevent tooth decay, there are thousands of communities where naturally occurring fluoride levels are deficient. It is in these places that small amounts of fluoride have been added to drinking water supplies, resulting in decreasing rates of tooth decay. Water fluoridation is extremely cost effective. Every dollar spent on community water fluoridation saves from \$7 to \$42 in treatment costs, depending on the size of the community.

Source: Surgeon General Statement on Community Water Fluoridation, December 3, 2001; DHS/Oral Health Program

Population Served by Floridated Water Systems

- Healthy People 2010 Objective: 75%
- United States: 68%
- Oregon: 20%
- Deschutes County: less than 1%

Source: Centers for Disease Control and Prevention; DHS / Drinking Water Program

Dental Care During Pregnancy

Fewer than half the women in Oregon seek needed dental care during pregnancy, and only one-third receive education on how to care for their infant's teeth.

Source: DHS / Oral Health Program

MENTAL HEALTH

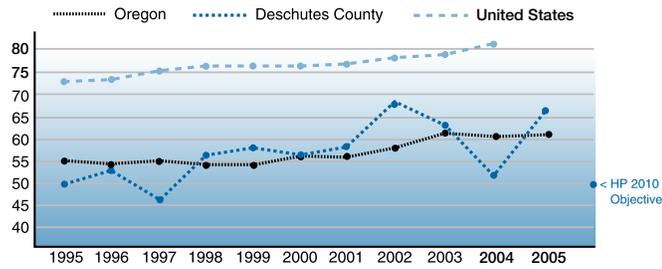
The National Institute of Mental Health estimates that 26.2% of Americans ages 28 and older (about one in four adults) suffer from a diagnosable mental disorder in a given year. When applied to the 2006 population estimates for Deschutes County, this figure translates to 29,559 Deschutes County residents. Although mental disorders are widespread in the population, the main burden of illness is concentrated in a much smaller proportion: About 6%, or 1 in 17, who suffer from a serious mental illness. Applied to Deschutes County, that would equal 6,955 individuals.

The annual prevalence of mental disorders among older adults (ages 55 years and older) is not as well documented as that for younger adults. The experience of loss with aging (loss of physical capacities, loss of social status and self-esteem, and the death of friends and loved ones) can lead to bereavement-associated depression. Among adults, suicide rates increase with age and are very high among those 65 years and older.

Source: Surgeon General Statement on Community Water Fluoridation, December 3, 2001; DHS/Oral Health Program

MATERNAL, CHILD & ADOLESCENT HEALTH

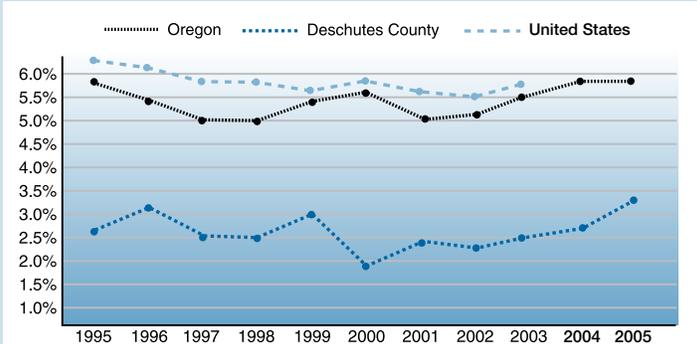
Low Birthweight Rate of Low Birthweight* Infants per 1,000



*Low birthweight is defined as under 2500 grams
Source: DHS/Oregon Center for Health Statistics; CDC/National Center for Health Statistics

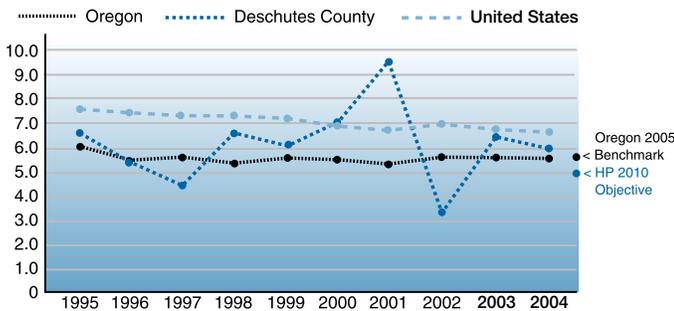
Deschutes County is still far from meeting the Healthy People 2010 objective of 50 low birthweight infants per 1,000 births. Low birthweight infants who survive are at increased risk for health problems ranging from neurodevelopmental disabilities to respiratory disorders.

Prenatal Care Percent of Pregnant Women getting Inadequate Prenatal Care*



*Inadequate prenatal care is defined as care that began in the third trimester or consisted of less than five prenatal visits.
Source: DHS/Oregon Center for Health Statistics

Infant Mortality Rate of Infant Mortality* per 1,000 Live Births



*Infant mortality is defined as the death of a child prior to its first birthday.
Source: DHS-Oregon Health Services, 2004

While the Deschutes County infant mortality rate has been consistently lower than the national rate, it is still significantly higher than the Healthy People 2010 objective of 4.5 per 1,000 live births. Factors that effect infant mortality include smoking, substance abuse, poor nutrition, lack of prenatal care, medical problems, and chronic illness. Early and continuous prenatal care helps identify conditions and behavior that can lead to infant deaths.

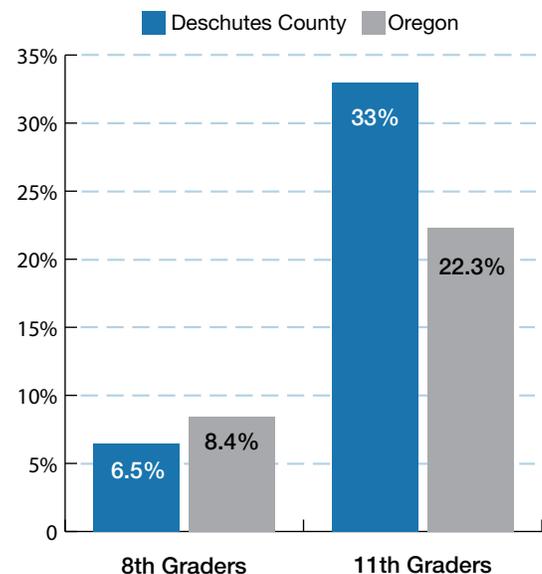
Percent of Women Receiving First Trimester Care

	1999	2000	2001	2002	2003	2004	2005
Deschutes County	83.5%	88.2%	89.7%	91.5%	90.0%	88.9%	90.2%
Oregon	80.9%	81.1%	81.5%	81.6%	81.1%	80.4%	81.0%
United States	81.3%	81.1%	81.5%	81.6%	81.1%	83.9%	N/A*
OR 2005 Benchmark							>>85%
Healthy People 2010							>>90%

Deschutes County has consistently ranked among the top Oregon counties with the highest rates of first trimester prenatal care. Early and continuous prenatal care is an important way to improve the long-term health of mothers and to prevent adverse birth outcomes.

* N/A = Not Available
Source: DHS/Center for Health Statistics; CDC/National Center for Health Statistics

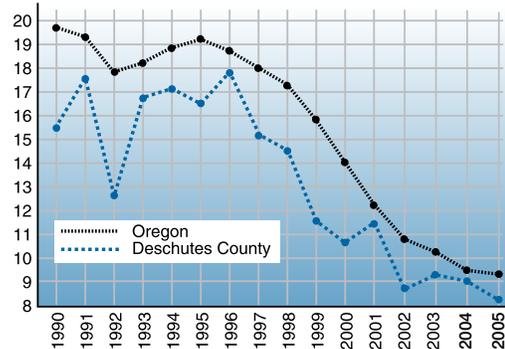
Sexual Intercourse with Two or More Partners, 2005-2006



Source: Oregon Healthy Teens Survey, 2005-2006

Teen Pregnancy Rate of Teen Pregnancy per 1,000 Females Ages 10-17

Teen pregnancy has decreased dramatically over the last several years and is at an all time low in both Deschutes County and Oregon.



* Preliminary rolling rate October 2004 - September 2005
Source: DHS-Oregon Health Services, 2004

Breastfeeding

The American Academy of Pediatrics (AAP) recommends that breastfeeding continue for at least one year. Breastfed babies are sick less than babies who are fed infant formula, and they have fewer ear aches, allergies, colds, and illnesses. These babies are also less likely to develop chronic conditions including obesity and diabetes later in life. Oregon's Women, Infants, and Children (WIC) program ranks **first in the nation** for breastfeeding initiation at 87.6%. The Deschutes County initiation rate is even higher. Of infants born between January 1, 2006 and September 25, 2006, who were enrolled in Deschutes County WIC and had their first certification before three months of age, 92.8% initiated breastfeeding. Both the County and State rate far surpass the Healthy People 2010 objective of 75% breastfeeding initiation.

Source: DHS/Oregon WIC Program; Centers for Disease Control and Prevention

Immunization

Population-based immunization rates are calculated to reflect the percentage of children considered "up to date" on their immunizations by two years of age. The rates are affected by multiple factors, including parental choice to delay vaccination and clinical decisions to provide vaccines at intervals different from the Recommended Schedule*. The vaccines included prevent ten diseases: diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, Haemophilus influenzae type b, hepatitis B, and chicken pox.

Percentage of Two-year-olds Fully Covered with Recommended* Vaccines, 2005

Deschutes County: 51.0% Oregon: 71.8%

*Vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). The Committee develops written recommendations for the routine administration of vaccines to the pediatric and adult populations. ACIP is the only entity in the federal government which makes such recommendations.

Source: DHS/Immunization Program

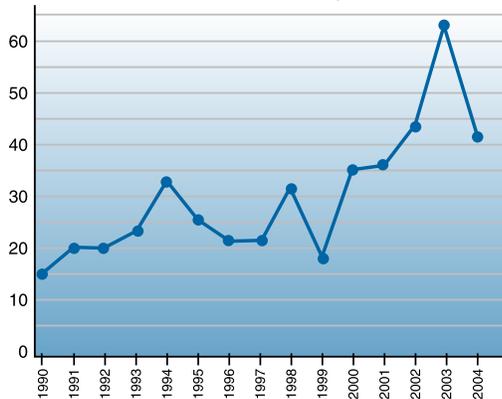
ADOLESCENT SUICIDE

In 2004, suicide claimed the lives of 67 Oregon youth aged 10-24 years. Suicide was the second leading cause of death among Oregonians aged 10-24 years. Oregon's youth suicide rate has been higher than the national rate for decades. For every suicide death among youth under 18 years, there are an estimated 134 suicide attempts that are treated in hospital emergency rooms. In Oregon in 2004, 81% of suicide

deaths in youth 24 years and under were among males, while 19% were among females. Firearms were used in 54% of Oregon youth suicide deaths. Factors associated with youth suicide include: prior suicide attempt, history of depression, substance abuse, family history of suicide, incarceration, firearm access and feelings of hopelessness.

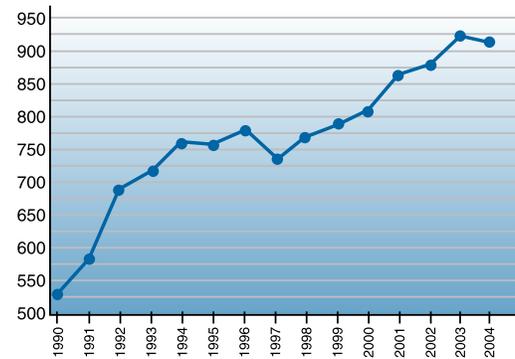
Sources: DHS/Center for Health Statistics, Youth Suicide Facts, 2006; Oregon Vital Statistics Annual Report, 2004, Volume 2, Morbidity

Deschutes Co. Adolescent Suicide Attempts*



Source: DHS/Center for Health Statistics

Oregon Adolescent Suicide Attempts*

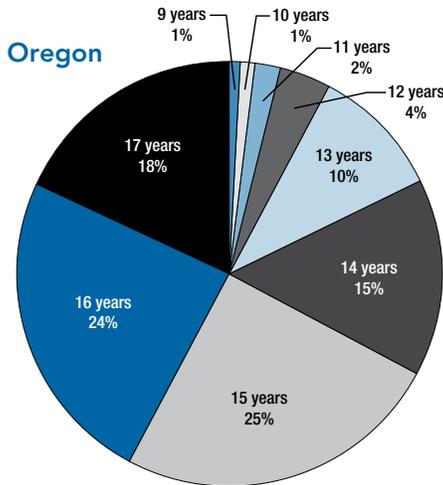


Source: DHS/Center for Health Statistics

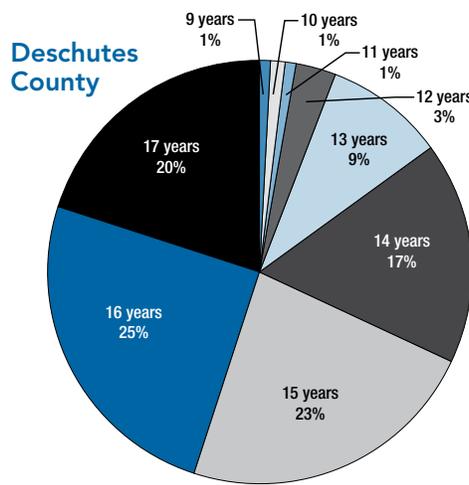
*These numbers reflect suicide attempts resulting in hospitalizations or deaths of children ages 10-17.

When health is absent, wisdom cannot reveal itself, art cannot manifest, strength cannot fight, wealth becomes useless, and intelligence cannot be applied.
 - Herophilus, Greek physician (335 BC - 280 BC)

Percentage of Adolescent Suicide Attempts by Age, 2000-2004



Source: DHS/Center for Health Statistics



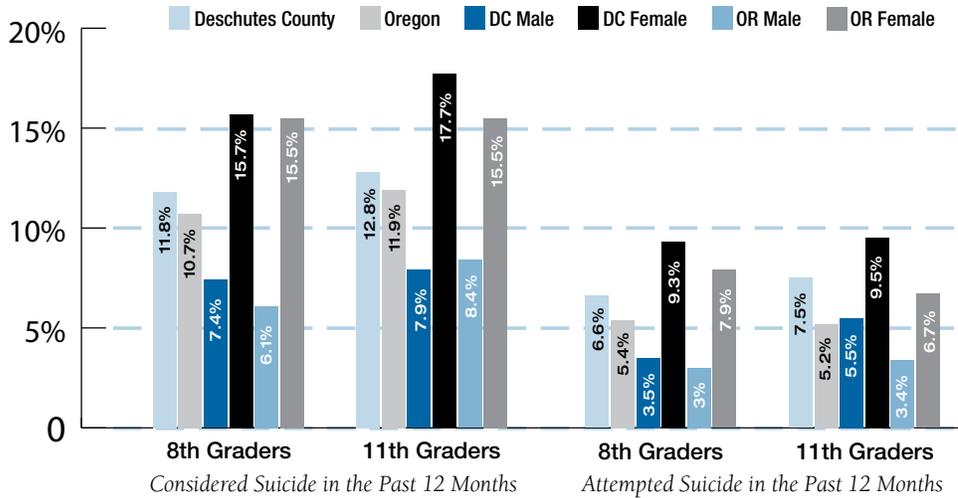
Source: DHS/Center for Health Statistics

Reasons given for Suicide Attempts, Oregon Minors, 2004

Reasons	Total
Total	852
Family Discord	487
School Related Problems	246
Argument w/ Boy/Girlfriend	180
Substance Abuse	118
Peer Pressure/Conflict	82
Rape or Sexual Abuse	65
Death of Family Member/Friend	49
Move or New School	47
Physical Abuse	42
Problems with the Law	34
Suicide by Friend/Relative	22
Pregnancy	7
Other Reasons	343

Source: DHS/Center for Health Statistics

Adolescent Mental Health 8th and 11th Graders, 2005-2006



Sources: Oregon Healthy Teens Survey, 2005-2006

Protective Factors

that shield people from the risks associated with suicide:

- Family and community support
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts
- Effective clinical care for mental, physical, and substance use disorders
- Easy access to a variety of clinical interventions and support

Child Abuse and Neglect

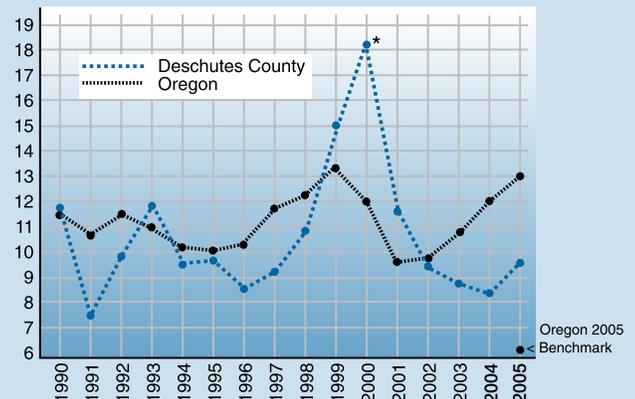
Foster Care - 10.1% of children in foster care in Deschutes County did not have stable placements in 2005, meaning that they were moved three or more times in the previous 12 months. Statewide, the percentage is 15.4%

Recurrence of Maltreatment - In 2005, 10.2% of child abuse/neglect victims in Deschutes County were re-abused within six months of prior victimization. Statewide, the percentage is 12.2%

Sources: Children First for Oregon

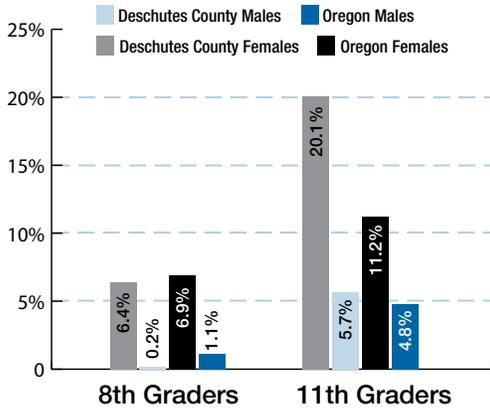
Rate of Children (under 18 years) who were Abused or Neglected**

*The sharp rise and fall of rates from 1999-2001 is attributed to changes in child abuse definitions and procedures.
** Per 1,000 persons under 18 years.



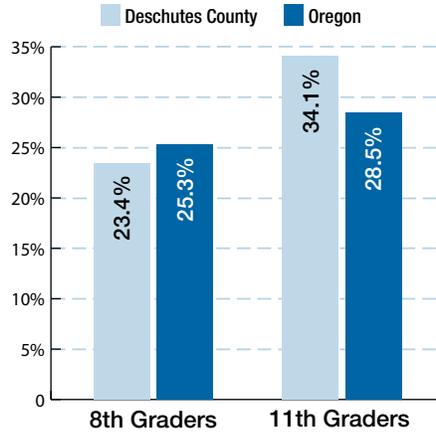
Oregon 2005 Benchmark

Sexual Contact from an Adult at Any Time During Life



Source: Oregon Healthy Teens Survey, 2005-2006

Intentional Physical Harm by an Adult



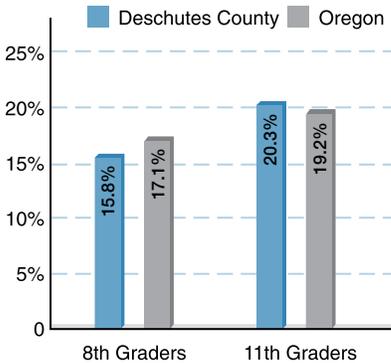
Source: Oregon Healthy Teens Survey, 2005-2006

KIDS Center

The KIDS Center serves approximately 450 children annually who need evaluation and treatment for sexual abuse, physical and emotional abuse, and neglect. The Center is also spearheading a revolutionary sexual abuse prevention training and outreach program in Central Oregon. This national research-based program, called Darkness to Light, educates adults to prevent, recognize, and react responsibly to child sexual abuse. It's estimated that for every adult trained in this program, 10 children are better protected. To find out more, call the KIDS Center Prevention Program at 541-312-5092

CHILDHOOD CHRONIC DISEASE

Asthma in Children Diagnosis of Asthma, 2005-2006



Childhood asthma is a disorder with genetic predispositions and a strong allergic component. Approximately 75 to 80 percent of children with asthma have significant allergies. Asthma is controllable through the proper use of medications and the reduction of exposure to asthma triggers.

Source: Oregon Healthy Teens Survey, 2005-2006; American Lung Association

Diabetes in Children

The national prevalence of diagnosed diabetes among people under 20 years of age is 0.22%. Applying this percentage to the local level, approximately 90 Deschutes County residents under 20 years of age are likely to have diabetes. Recent studies suggest that type 2 diabetes in children and adolescents (previously thought of as adult-onset diabetes), although still rare, is being diagnosed more frequently. This trend is thought to be tied to rising obesity rates in children and adolescents.

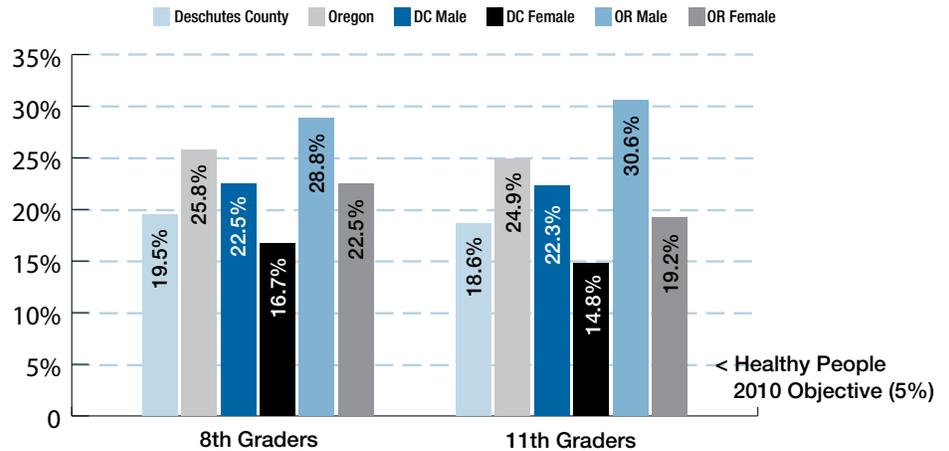
Source: Centers for Disease Control and Prevention

Overweight & Obesity* in Children Overweight or At Risk for Overweight, 2005-2006

There has been a startling rise in obesity rates in children over the past two decades. The trend is occurring throughout the United States, in all age groups, across all socioeconomic strata, and among all ethnic groups. Although Deschutes County is doing better compared to Oregon as a whole, the percentage of overweight and obese children in the County still far exceeds the Healthy People 2010 objective, which calls for only 5% of children and adolescents as overweight or obese.

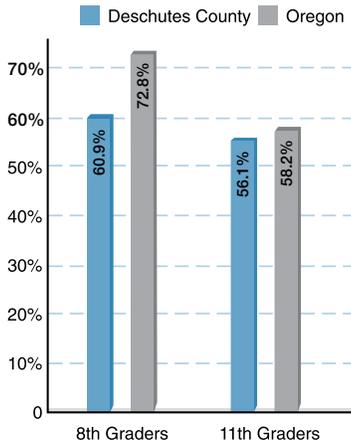
*In those aged 6 to 19 years, overweight or obesity is defined as at or above the sex- and age-specific 95th percentile of Body Mass Index (BMI) based on CDC Growth Charts.

Source: Oregon Health Teens Survey, 2005-2006; Centers for Disease Control and Prevention



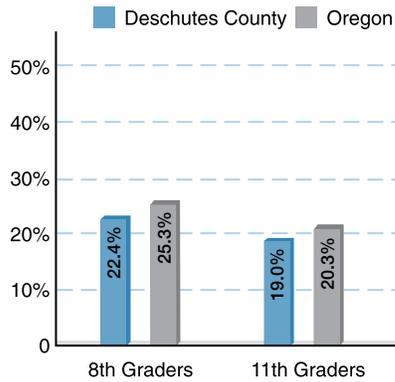
Nutrition and Physical Activity in Children

Physically Active Four or More Days During the Past Week*, 2005-2006



*For a total of at least 60 minutes per day
 Source: Oregon Health Teens Survey, 2005-2006

Consumption of 5 Fruits and Vegetables Daily, 2005-2006



Source: Oregon Health Teens Survey, 2005-2006

Public Health Defined

“Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy.”

-Institute of Medicine

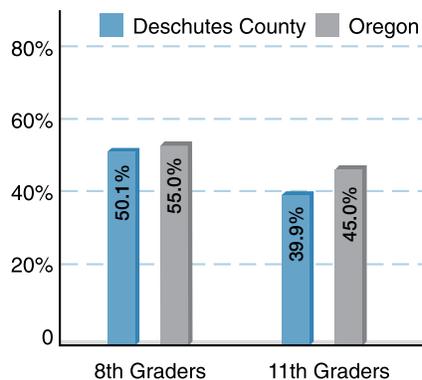
Regular physical activity and the consumption of at least five servings of fruits and vegetables per day has been shown to have a protective affect against certain cancers, a reduced risk of cardiovascular disease and high blood pressure, and is an effective strategy to prevent obesity. **Deschutes County eighth and eleventh graders fall short of state averages for both physical activity and daily consumption of fruits and vegetables.**



Screen Time

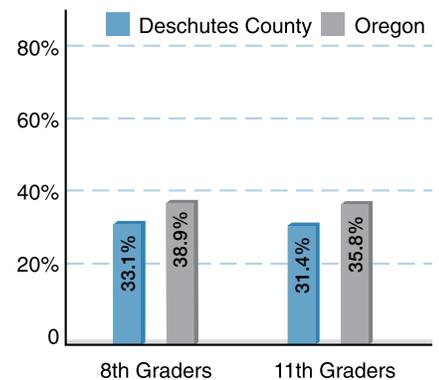
The amount of time spent utilizing a computer, television, video games, and text messaging has become known as “screen time.” Significant time spent utilizing these various types of media is thought to be a contributing factor to rising obesity trends throughout the country. According to a 2005 Kaiser Family Foundation report, children ages 8 to 18 spend more time (44.5 hours per week) in front of computer, television, and game screens than any other activity in their lives except sleeping.

Spend 2+ Hours Watching TV Daily* 2005-2006



*on an average school day
 Source: Oregon Health Teens Survey, 2005-2006

Spend 2+ Hours on Internet or Video Games Daily* 2005-2006



*on an average school day
 Source: Oregon Health Teens Survey, 2005-2006

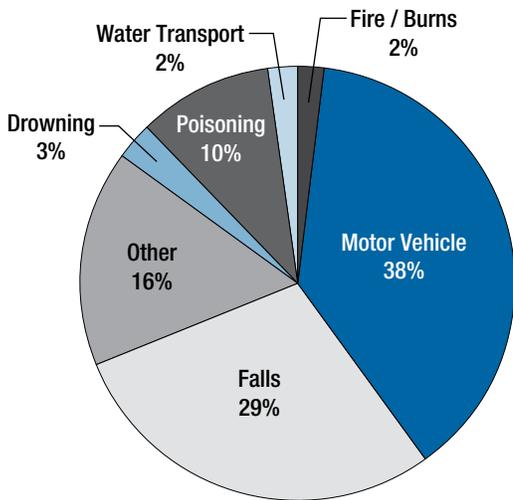
UNINTENTIONAL INJURY

Injuries, both violent and unintentional, are a significant public health issue. According to the Centers for Disease Control and Prevention, injuries claim more potential years of life lost prematurely before age 65 than any other cause of death. While injury is the fourth leading cause of death in the United States, it is **the leading cause of death for children and young adults** between 1 and 44 years of age. Extensive research has shown that injuries are similar to diseases in that injuries are not accidents, do not occur at random, and have identified risk and protective factors making them preventable.

For children in particular, risk occurs primarily because of environments where heavy neighborhood traffic makes outdoor play areas unsafe or where safety devices, such as bicycle helmets, car seats, or smoke detectors, are unaffordable or may seem less important than other necessities. By implementing proven interventions, such as child car seats, environmental measures to lessen traffic speed and volume in neighborhoods, bicycle helmets, and smoke detectors, injury deaths among children can be reduced significantly.

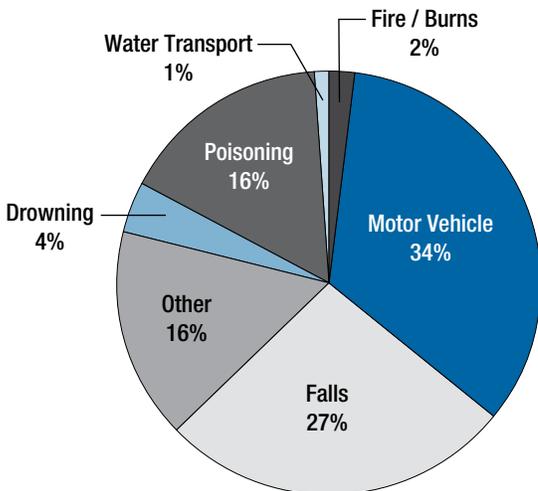
Sources: Centers for Disease Control and Prevention; Society for Public Health Education

Unintentional Injury Deaths
Deschutes County, 2004



Source: DHS/Center for Health Statistics

Unintentional Injury Deaths
Oregon, 2004



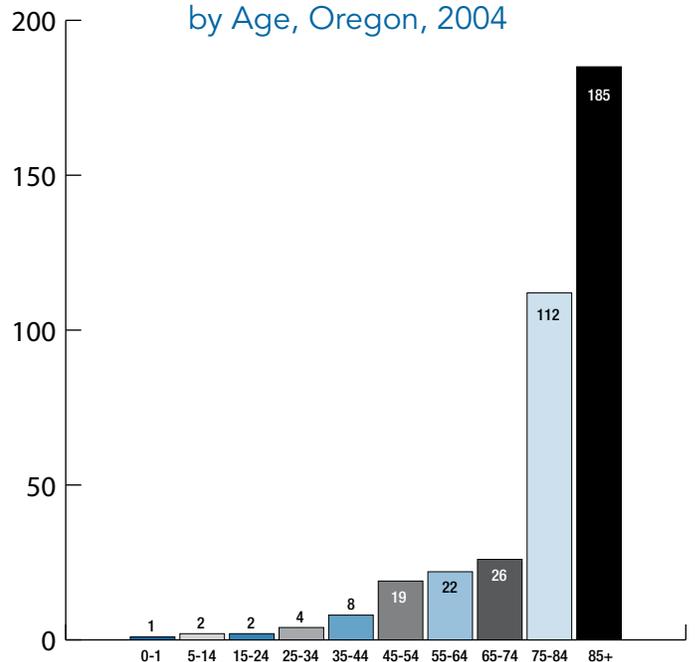
Source: DHS/Center for Health Statistics

	1999	2000	2001	2002	2003	2004	Total
Oregon	1,144	1,211	1,257	1,382	1,388	1,423	7,805
Deschutes County	39	45	42	39	56	58	279

Of the 279 unintentional injury deaths in Deschutes County, 133 were due to motor vehicle accidents (47.7%). Fifty-six were due to falls (20.1%).

Sources: DHS/Center for Health Statistics

Unintentional Fatal Falls
by Age, Oregon, 2004



The risk of fatal falls increases significantly with age. While the all-age death rate for Oregon is 10.63 per 100,000, the death rate for those 75 years and older is 129.58. Many falls can be prevented through modifications to the living environment, regular vision checks, and exercise.

Sources: DHS/Center for Health Statistics; Centers for Disease Control and Prevention

Domestic Violence

Intimate partner violence (IPV) is a public health problem that impacts individuals, families, and communities throughout Oregon. A survey conducted in 2001-2002 found that one in ten Oregon women age 20-55 experienced IPV (defined as physical and/or sexual assault by an intimate partner) in the five years preceding the survey, equaling more than 85,000 women. Applied to the local level, that would equal approximately 11,000 women in Deschutes County.

- The Central Oregon Battery and Rape Alliance (COBRA) answered 1,930 hotline calls from Deschutes County residents in 2005.
- COBRA provided shelter to 125 adults and 148 children in Deschutes County in 2005.

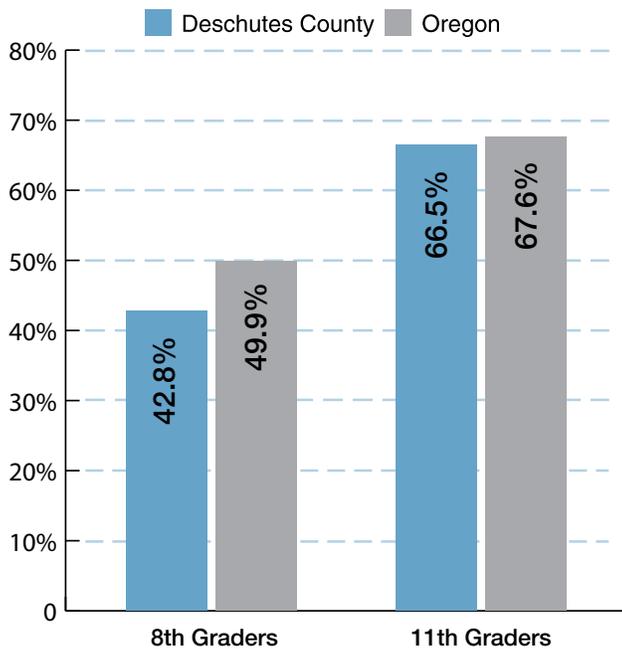
Source: DHS/Injury and Violence Prevention Program; Central Oregon Battery and Rape Alliance (COBRA)

All-Terrain Vehicle (ATV) Deaths and Injuries

- In the United States, between 1982-2003, there were 5,791 ATV-related deaths. Thirty-two percent of those deaths occurred among children under age 16.
- In Oregon, between 1999-2004, 18 children under age 18 died as a result of ATV-related injuries. The average age of death was 13.7 years. Only two of these children were wearing a helmet at the time of the incident.
- Since 1999, the number of hospital admissions among children in Oregon for major trauma due to ATV-related injuries has increased by 146.

Source: DHS/Office of Disease Prevention and Epidemiology, CD Summary, May 16, 2006

Rarely or Never Wore a Bike Helmet During Past 12 months*, 2005 - 2006



*Among those who rode a bicycle during that time

Source: DHS/Office of Disease Prevention and Epidemiology, CD Summary, May 16, 2006

Concussion in Teen Sports

Mild Traumatic Brain Injury (MTBI), commonly known as concussion, arises from blunt trauma or acceleration or deceleration forces to the head. While many youth - and even coaches or parents - may not consider the injury serious, the reality is that up to 15% of MTBI patients experience persistent disabling conditions. In addition, youth who have sustained an MTBI and **return to play before healing has occurred are three times more likely to sustain another MTBI**, which can cause longer-lasting damage, such as brain swelling, permanent brain damage, and (rarely) even death.

Oregon data: Using injury rates from a recent study conducted by the Centers of Disease Control and Prevention, the Oregon Injury Prevention Program estimated that at least 8,500 injuries, including **678 MTBIs**, were experienced by Oregon student athletes in the 2004-2005 school year.

Source: CD Summary, December 12, 2006, Vol. 55, No. 25; DHS/Injury Prevention Program; Centers for Disease Control and Prevention

Sport	MTBI as % of injuries	Estimated concussions	Rate / 1000 exposures
Girls soccer	15%	96	0.35
Girls basketball	12%	86	0.24
Boys basketball	3%	28	0.07
Football	10%	348	0.44
Boys soccer	10%	72	0.23
Wrestling	5%	34	0.12

Violent Injury Firearm Deaths, 1997 - 2004

	1997	1998	1999	2000	2001	2002	2003	2004
Oregon	428	441	391	378	360	376	393	383
Deschutes County	15	13	13	N/A*	16	21	12	17

*County level data not available for 2000

Source: DHS/Center for Health Statistics

Of the 107 firearm deaths in Deschutes County, 1997-2004 (excluding 1999), 91 were due to suicide (85%). In Oregon, of the 3,150 firearm deaths, 2,493 were due to suicide (79%).

SUBSTANCE ABUSE

Tobacco Adults

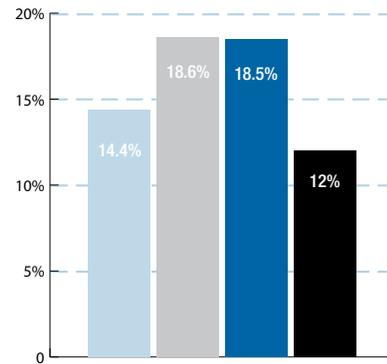
Tobacco use remains the leading preventable cause of death in the United States, causing nearly 440,000 deaths each year and resulting in an annual cost of more than \$75 billion in direct medical costs. More than 8.6 million people in the United States have at least one serious illness caused by smoking. Tobacco use is steadily declining in Deschutes County but still remains higher than both state and national objectives. Rates are especially high among County youth.

- In 2004, 22.6% of all deaths in Deschutes County were tobacco-related. Tobacco-related deaths are mainly due to three causes: cardiovascular disease, cancers, and respiratory disease.

Sources: DHS/Center for Health Statistics

Tobacco Use (Smoking), Adults, 2005

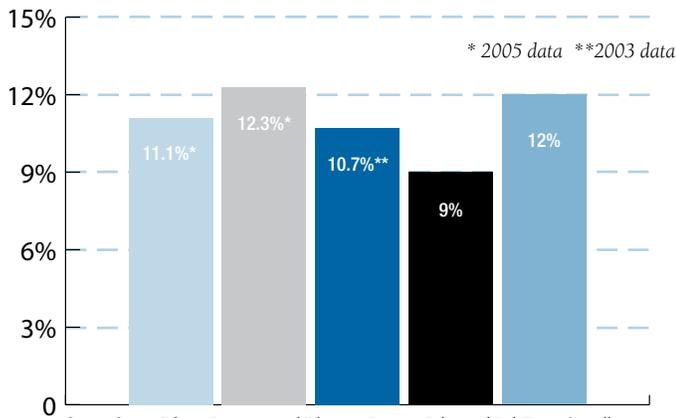
Deschutes County Oregon United States Healthy People 2010 Objective



Source: Oregon Tobacco Prevention and Education Program; Behavioral Risk Factor Surveillance System, 2005; Centers for Disease Control and Prevention

Pregnant Women Who Use Tobacco (Smoking)

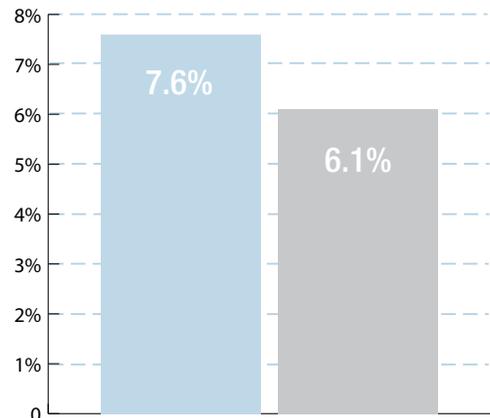
Deschutes County Oregon United States 2005 Oregon Benchmark Healthy People 2010 Objective



Source: Oregon Tobacco Prevention and Education Program; Behavioral Risk Factor Surveillance System, 2005; Centers for Disease Control and Prevention

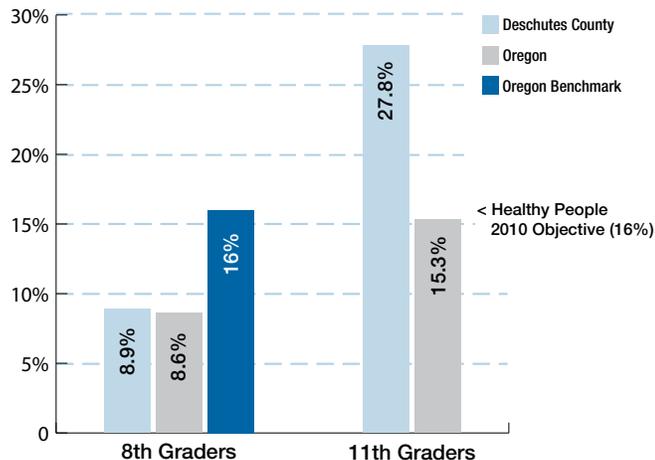
Smokeless Tobacco*, Adults, 2005

Deschutes County Oregon



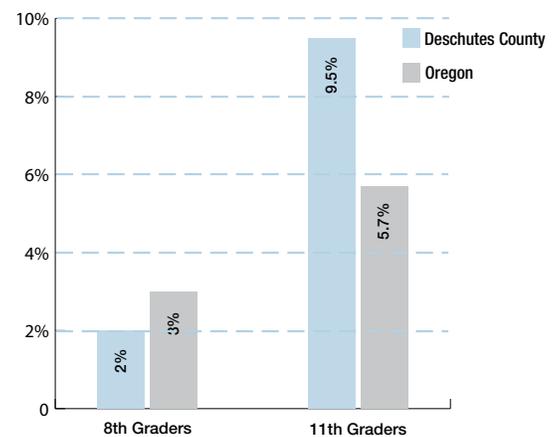
Source: Oregon Tobacco Prevention and Education Program

8th and 11th Graders who Smoked Cigarettes in the Past 30 Days, 2005-2006



Source: Oregon Healthy Teens Survey, 2005-2006; Centers for Disease Control and Prevention

8th and 11th Graders Who Used Smokeless Tobacco in the Past 30 Days, 2005-2006



Source: Oregon Healthy Teens Survey, 2005-2006

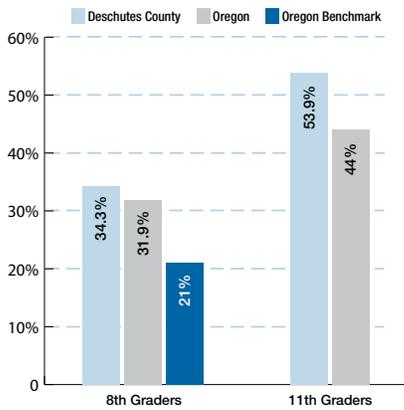
ALCOHOL AND ILLICIT DRUG USE

Alcohol is the most commonly used and abused drug among youth in the United States. Age at first use of alcohol is an important indicator of future consumption. Youth who use alcohol before the age of 15 are five times more likely to develop alcohol dependence as an adult.

These youth are also more likely to develop other drug dependency problems. Prevention and intervention can help to reduce risk factors and boost protective factors that guard against initiation of alcohol and drug use.

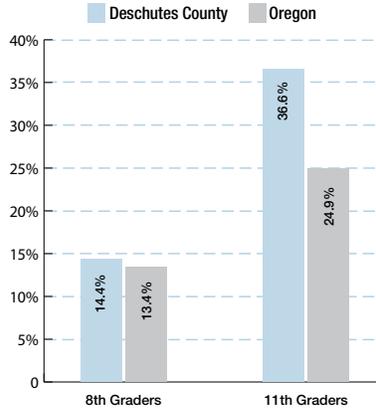
Source: Centers for Disease Control and Prevention

**8th and 11th Graders:
Use of Alcohol at Least Once
in the Past 30 Days, 2005-2006**



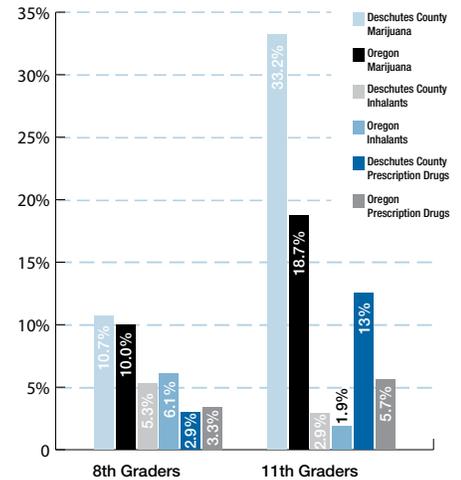
Source: Oregon Healthy Teens Survey, 2005-2006; Centers for Disease Control and Prevention

**8th and 11th Graders:
Binge Drinking*
in the Past 30 Days, 2005-2006**



* Five or more drinks of alcohol in a row
Source: Oregon Healthy Teens Survey, 2005-2006; Centers for Disease Control and Prevention

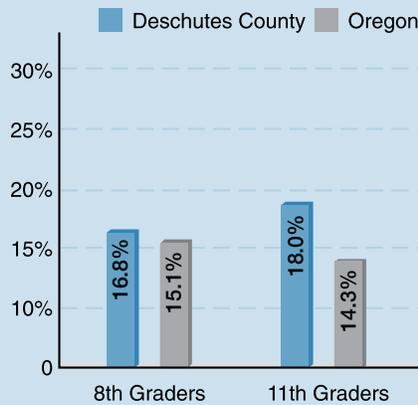
**8th and 11th Graders:
Use of Illicit Drugs within
the Past 30 Days, 2005-2006**



Source: Oregon Healthy Teens Survey, 2005-2006

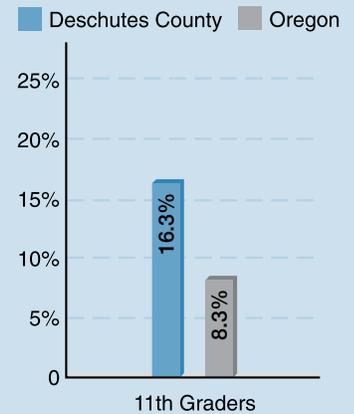
During the Past 30 Days, Rode With a Parent or Other Adult Driver Who Had Been Drinking, 2005-2006

Source: Oregon Healthy Teens Survey, 2003

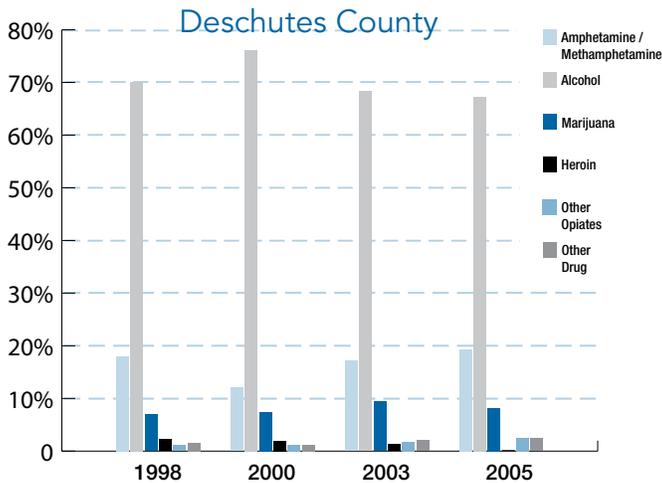


11th Graders Who Drank Alcohol and Drove at Least Once, 2005-2006

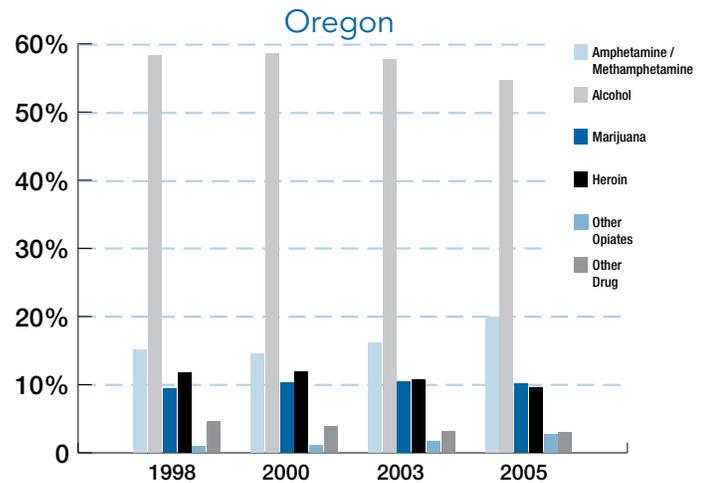
Source: Oregon Healthy Teens Survey, 2003



Treatment by Primary Substance Abused



Source: DHS/Addictions and Mental Health Division



Source: DHS/Addictions and Mental Health Division

METHAMPHETAMINE

Methamphetamine, or “meth”, is a highly addictive, synthetic stimulant drug that affects the central nervous system. The ingredients used to manufacture meth are highly toxic and include benzene, paint thinner, Drano, battery acid, ephedrine, white gas, starter fluid, and more. Chronic meth use can lead to psychotic behavior and debilitating health effects, such as extreme weight loss, the development of open sores on the face and arms, cardiovascular complications, and a severe decline in oral health. The manufacture of meth exposes humans, animals, and the environment to toxic and explosive chemicals.

Disease Transmission

Disease transmission among meth users is a very real possibility. In a July 2005 survey of Deschutes County Jail inmates, 60% of admitted meth users acknowledged injection as the primary route of exposure. Of the injection drug users, 35% reported that within the past six months they had used needles or other injection equipment that had been previously used by someone else. Because of this, injection drug users are vulnerable to a diverse range of infectious and communicable diseases, including HIV and hepatitis C, which can result in considerable morbidity and mortality. It can also result in the spread of these diseases to others in the community, including those who do not use drugs. Unfortunately, intensive treatment geared for meth addicts is limited in Central

Oregon. Users often face waits of up to two weeks for treatment, during which time many of them relapse.

- In 1999, Deschutes County was designated a “High-Intensity Drug Trafficking Area” (HIDTA), a federal label for areas within the United States that exhibit serious drug trafficking problems.
- In 2005, the Deschutes County Sheriff’s Office had 328 arrests due to meth possession – 14% of the total arrests for the year.

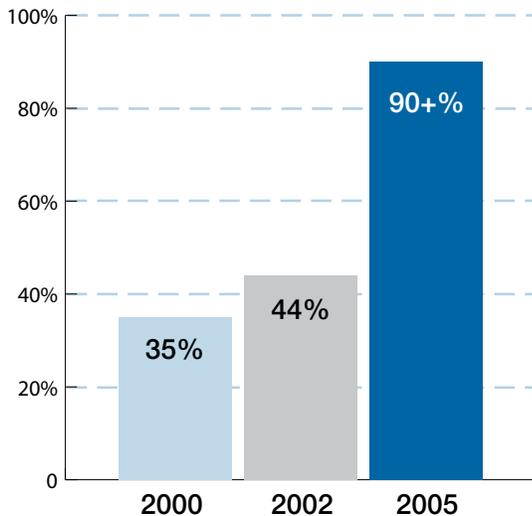
Meth Seizures

- From 7/1/04-6/30/05, the CODE Team* seized 13.8 pounds of meth.
- From 7/1/05-6/30/06, the CODE Team seized 12.9 pounds of meth.
- During just the first quarter of 06/07, the CODE Team seized over 8.5 pounds of meth.

**The Central Oregon Drug Enforcement team is a multi-agency narcotics investigation team comprised of detectives from the Bend Police Department, Deschutes County Sheriffs Department, Redmond Police Department, Prineville Police Department, Crook County Sheriffs Department, Jefferson County Sheriffs Department, Deschutes County District Attorneys Office, United States Drug Enforcement Administration, and the Oregon National Guard.*

Source: Central Oregon Drug Enforcement Team; Deschutes County Mental Health Department; Deschutes County Sheriffs Office; Deschutes County Health Department; Office of National Drug Control Policy; KIDS Center

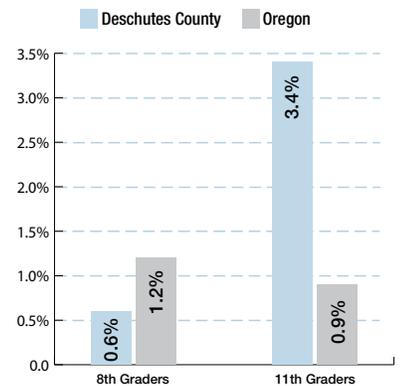
Purity* of Meth seized in Central Oregon



*The purity of meth directly relates to its addictiveness. The higher the purity, the more addictive the drug. Only super labs found in Mexico and California are able to produce meth of such high purity, which means that most meth in Central Oregon is now transported here, not manufactured here.

Source: Central Oregon Drug Enforcement (CODE) Team

8th & 11th Graders: Use of Methamphetamines within the Past 30 Days, 2005 - 2006



Source: Oregon Healthy Teens Survey, 2005-2006

Deschutes County Clients of the KIDS Center

In 2005, 25% of the caregivers that brought children to the KIDS Center for a child abuse evaluation self-reported that there was meth in the home environment. In 2006, 27% disclosed meth in the home. These numbers are thought to be an under-representation due to the reluctance in self-reporting meth use around children.

A December, 2006 point-in-time survey of KIDS Center therapists found that 61% of therapy clients have meth in their home environments. This figure is more likely an accurate representation of the problem given that therapists build trust with kids and their families over an extended period of time.

Source: KIDS Center

ENVIRONMENTAL HEALTH

Drinking Water

- All properly tested water from community water systems in Deschutes County currently meets federal drinking water standards.
- There were no waterborne disease outbreaks in Deschutes County throughout 2004-2005, however there were four E. coli/boil water alerts. All were taken care of and there were no reported human cases as a result.

Source: Deschutes County Environmental Health Division

Food Safety

Deschutes County has approximately 650 food service establishments. Each of these is inspected twice a year, matching the most per capita anywhere in the state. In addition, the summer season brings over 300 temporary restaurants that require inspection.

- Deschutes County Public and Environmental Health investigated over 100 food borne illness complaints in 2005.

Source: Deschutes County Environmental Health Division; Deschutes County Health Department

Hazardous Waste

- Currently there are 109 environmental cleanup sites throughout Deschutes County, as listed by the Oregon Department of Environmental Quality. To be included on the list, the sites have known or suspected hazardous substance contamination.
- There are currently no federal Superfund sites in Deschutes County.

Sources: Oregon Department of Environmental Quality, Environmental Cleanup Site Information Database, 12-04-2006; United States Environmental Protection Agency

Outdoor Air Quality

The 1990 Clean Air Act reduced emissions from industry to less than 15% of pollutants. Motor vehicles are now the primary source of air pollution in Oregon. Emissions from cars contribute to ground level ozone pollution (smog), especially on hot summer days. Other major causes of pollution are from wood stoves, gas-powered lawn mowers, motor boats, paints, solvents, aerosols, and outdoor burning. In 2005, Deschutes County had 346 days ranked at the highest level of the Air Quality Index (“good”) and 19 ranked as “moderate.”

- Deschutes County is in compliance with all federal air quality standards.

Source: Oregon Department of Environmental Quality, 2005 Oregon Air Quality Data Summaries

Solid Waste

Deschutes County is among the highest producing counties in Oregon for pounds of municipal solid waste landfilled or incinerated per capita. The two main contributors are construction waste resulting from rapid population growth and waste from the tourism-based economy.

- Deschutes County ranked 16th of Oregon counties in

the amount of solid waste “recovered” per capita in 2005. Recovery refers to solid waste that is recycled, composted, or used in energy recovery.

- Of the 62,523 tons of recovered waste in Deschutes County in 2005, 72% was recycled, 23% was composted, and 5% was burned for energy.

Pounds of Municipal Solid Waste Disposed Per Capita, 1992 - 2005

	1992	1994	1996	1998	2000	2002	2004	2005
Oregon	1,513	1,483	1,539	1,609	1,617	1,554	1,630	1,667
Deschutes County	1,720	2,155	2,070	1,884	1,904	2,049	2,237	2,240
Oregon Benchmark								1,575

Source: DHS/Environmental Toxicology Program; Deschutes County Health Department

Recreational Water and Blue-Green Algae

Most algae are harmless, but there are several species of blue-green algae that may produce harmful toxins. During warm weather periods, blue-green algae blooms may concentrate to hazardous levels. Advisories are issued when cell counts exceed certain limits or when potentially harmful toxin levels are found. Toxins in water may be absorbed by humans when swallowed and when inhaled as droplets or spray in the air, potentially causing harmful short-term and long-term health effects. Pets and other animals are also at risk. Since June 2004, health advisories have been issued at four bodies of water in Deschutes County because of significant blooms of blue-green algae: Lava Lake, Crane Prairie Reservoir, Paulina Lake, and Wickiup Reservoir.

Source: DHS/Environmental Toxicology Program; Deschutes County Health Department

Vector Borne Diseases: West Nile Virus

West Nile Virus (WNV) is transmitted to humans and animals through the bite of infected mosquitoes. The vast majority of those infected with the virus have no symptoms or have a mild fever and flu-like illness. In rare cases, the virus can cause encephalitis, an inflammation of the brain, or death. WNV was first detected in Oregon in August 2004 with the first human, horse, and bird cases diagnosed. Since then, cases have increased significantly in Oregon, resulting in one human death in 2006. There have been no human cases acquired in Deschutes County. The Deschutes County Health Department continues to conduct surveillance of WNV through the testing of mosquitoes and dead birds.

West Nile Virus, Human Cases, Oregon, 2005

2004 - 1
2005 - 8
2006 - 70*

*Includes 3 cases that were acquired out of state

Source: DHS/Office of Disease Prevention and Epidemiology, Communicable Disease Surveillance Report, 2005

WHY RECYCLE?

There are significant energy savings and greenhouse gas reductions made as a result of recovered waste. For example, making aluminum from old beverage containers uses 93% less energy than making aluminum from bauxite. Newsprint made from old newspapers requires 43% less energy to make than newsprint made from wood. Additionally, net greenhouse gas reduction associated with materials recycled, composted, and burned for energy in 2005 are estimated at 3.3 million metric tons of carbon dioxide equivalent. The Oregon Department of Environmental Quality estimates that number to be comparable to removing 710,000 average passenger cars from Oregon roads.

Source: State of Oregon Department of Environmental Quality

COMMUNICABLE DISEASE

Sexually Transmitted Infections (STIs)

The number of STIs reported and requiring clinical follow-up in Deschutes County has increased by 314% since 1998.

CHLAMYDIA

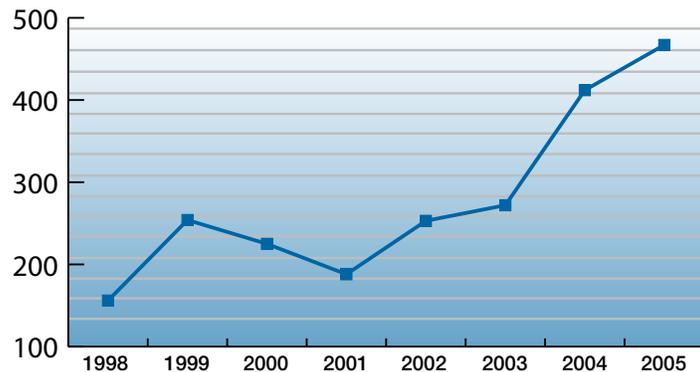
In 2006, Chlamydia accounted for over 97% of the STD diagnosis in Deschutes County. Chlamydia, a bacterial infection, is transmitted through oral, vaginal and anal sex. Although curable, it can have severe consequences including infertility and problems in newborns of infected mothers. Symptoms of Chlamydia are often mild or absent, which can delay diagnosis long enough to cause serious complications.

Deschutes County STI Cases, 1998-2006

	Chlamydia	Gonorrhea	Early Syphilis
1998	73	0	0
1999	145	7	0
2000	170	5	0
2001	207	11	1
2002	197	6	0
2003	177	3	1
2004	280	6	1
2005	314	8	1
2006	372	7	3

Communicable Disease Cases

Requiring Epidemiological Investigation, Excluding STIs



The number of communicable disease cases requiring in-depth epidemiological investigation in Deschutes County has increased by nearly 200% since 1998.

Source: Deschutes County Health Department

HIV/AIDS

Oregon instituted HIV reporting in October 2001, as part of a national effort to better track infection rates and to present a more accurate epidemiological picture of the problem in our state. Prior to HIV reporting, only diagnosed AIDS cases were reported to the State. Since HIV reporting began, Deschutes County has reported a total of 32 confirmed, HIV positive tests. While the numbers may seem small, it is important that they be understood in the appropriate context. They cannot be considered a true picture of HIV in this community for several reasons: HIV reporting began just five years ago, many people get tested for HIV outside of Deschutes County and then move here at a later date, and only about half of all persons in the United States report ever having been tested for HIV, meaning that there is a significant number of persons living with HIV who do not yet know it.

There are currently 55 HIV positive clients enrolled in the Ryan White Case Management Program with the Deschutes County Health Department. Case managers help determine eligibility for prescription drugs, health insurance, housing, disability, medical and dental care, and mental health counseling. It is anticipated that HIV caseloads will grow steadily over the next few years as more people move into the area and local opportunities for testing become increasingly available. Additionally, the implementation of named reporting of HIV infection will assist in accurately determining the severity of the epidemic and effectively slow its spread through enhanced partner notification. The Centers for Disease Control and Prevention recommends that everyone seriously consider being tested for HIV at least once, as there are estimated to be over 250,000 U.S. citizens with HIV who are not even aware they have the virus.

HIV/AIDS, Deschutes County and Oregon, 2000-2005

	Deschutes AIDS Cases	Deschutes HIV+ Cases	Oregon AIDS	Oregon HIV+
2000	4	N/A*	201	N/A*
2001	3	N/A*	253	N/A*
2002	5	16	262	716
2003	5	1	174	321
2004	3	7	208	288
2005	2	8	140	284

*HIV+ reporting began in October 2001

Source: DHS/Office of Disease Prevention and Epidemiology, Communicable Disease Surveillance Report, 2005

GIARDIASIS

Giardiasis is a diarrheal illness caused by the parasite, *Giardia Lamblia*. *Giardia* is one of the most common causes of waterborne disease (drinking and recreational) in humans in the United States. Symptoms generally begin 1-2 weeks after becoming infected and last 2-6 weeks.

Giardiasis Cases, 1998-2005

	Deschutes County	Oregon
1998	89	839
1999	102	896
2000	53	789
2001	34	514
2002	29	435
2003	21	402
2004	28	439
2005	11	419

Source: DHS/Office of Disease Prevention and Epidemiology; Deschutes County Communicable Disease Program

CAMPYLOBACTERIOSIS

Campylobacter is the most common bacterial cause of diarrhea in the United States. Most cases occur as single cases in the summer months and not as part of a large outbreak. Campylobacteriosis is a bacterial infection that affects the intestines and, on rare occasions, the bloodstream. *Campylobacter* is usually spread by eating or drinking contaminated food or water. It is sometimes spread through contact with infected people or animals. Symptoms generally appear 2-5 days after the contact is made. Most people will recover without any formal treatment.

Campylobacter, 1998-2005

	Deschutes County	Oregon
1998	89	839
1999	102	896
2000	53	789
2001	34	514
2002	29	435
2003	21	402
2004	28	439
2005	11	419

Source: DHS/Office of Disease Prevention and Epidemiology; Deschutes County Communicable Disease Program

OTHER COMMUNICABLE DISEASES

- Norwalk-like viruses are very contagious and can spread easily from person to person. Symptoms include nausea, vomiting, diarrhea, and some stomach cramping. In most people the illness is self-limiting with symptoms lasting for about 1 or 2 days, with no long-term health effects related to their illness. While not reportable in Oregon by law,

the Deschutes County Health Department investigates numerous outbreaks throughout the year.

- Pertussis, or whooping cough, is a highly contagious respiratory disease caused by a bacterium found in the mouth, nose and throat of an infected person. Pertussis poses significant risk for hospitalization and death of infants (less than 6 months). In 2004, Oregon experienced an upswing in the number of pertussis cases, reaching the highest level since 1959. More than 80% of all cases were located in Benton, Lane, Douglas, and Clackamas counties. Deschutes County had two confirmed cases.

- Hepatitis C is a liver disease caused by a virus spread through needle-sharing, occupational needlesticks, and in childbirth by infected mothers. While 80% of infected people have no symptoms, the infection can lead to serious liver disease. A new reporting process, begun in 2005, is anticipated to provide a more accurate picture of the burden in Deschutes County. There were 290 positive lab reports of Hepatitis C in 2005.

- Influenza. On average, 5%-20% of the American population gets the flu each year, resulting in 36,000 deaths nationwide. Deschutes County had 15 deaths due to influenza/pneumonia in 2004.

Source: DHS/Office of Disease Prevention and Epidemiology; Deschutes County Communicable Disease Program

PANDEMIC PLANNING

In cooperation with local and statewide partners, the Deschutes County Health Department conducted a pandemic exercise on November 1-2, 2006. The Health Department is continuously improving plans for preparedness by working with the Deschutes County Emergency Manager to coordinate response to events. Partners in that process include schools, health systems, and local business establishments.



DID YOU KNOW?

There is a new rapid HIV test that gives accurate results in just 20 minutes. Testing is available at several locations throughout Deschutes County.

DATA SOURCES

Oregon Healthy Teens Survey

Since 2000, the Youth Risk Behavior Survey and the Oregon Public School Drug Use Survey have been combined into a single annual survey, Oregon Healthy Teens. The OHT is Oregon's effort to monitor the health and well-being of adolescents through a comprehensive, school-based, anonymous and voluntary survey. OHT is conducted among 8th and 11th graders statewide.

<http://www.dhs.state.or.us/dhs/ph/chs/youthsurvey>

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing random-digit dialed telephone survey of adults concerning health-related behaviors. The BRFSS was developed by the Centers for Disease Control and Prevention and is conducted in all states in the United States. Each year, 3,000-15,000 adult Oregonians are interviewed on questions related to health behavior risk factors such as seat belt use, diet, weight control, tobacco and alcohol use, physical exercise, preventive health screenings, and use of preventive and other health care services. The data are weighted to represent all adults aged 18 years and older. Each state may add questions to the CD survey. <http://www.cdc.gov/brfss>

Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention (CDC) is one component of the federal Department of Health and Human Services (HHS). This serves as the principal agency in the United States government for protecting the health and safety of all Americans. The CDC's mission is to promote the health and quality of life by preventing and controlling disease, injury, and disability. <http://www.cdc.gov>

DHS/Center for Health Statistics

The Center for Health Statistics (CHS) is responsible for registering, certifying, amending, and issuing Oregon vital records. <http://www.dhs.state.or.us/dhs/ph/chs>

DHS/Office of Disease Prevention and Epidemiology

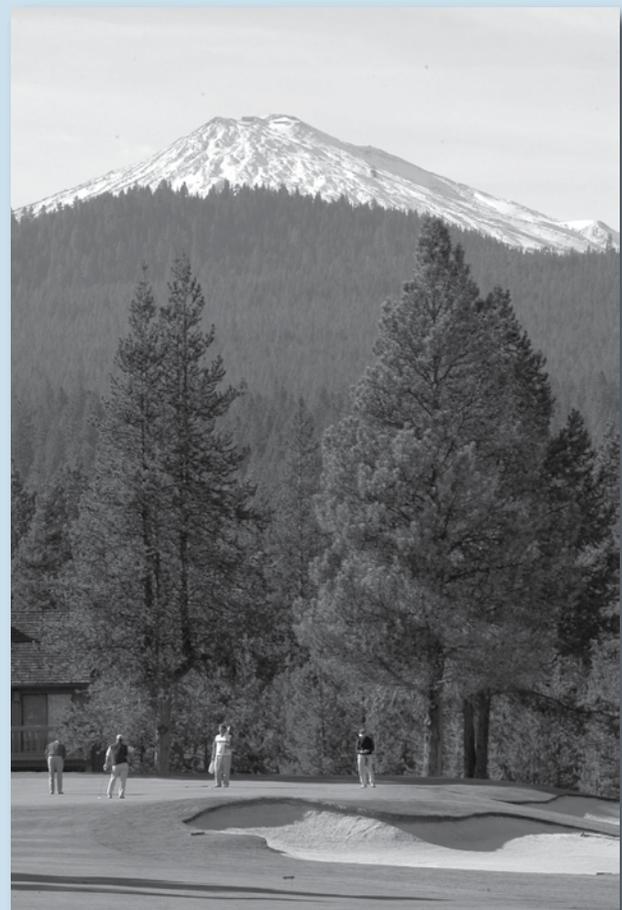
The Office of Disease Prevention and Epidemiology identifies, monitors and seeks to control the factors that threaten the health of Oregonians. The Office is comprised of the following programs: Injury Prevention and Epidemiology, HIV/STD/TB Program, Health Promotion and Chronic Disease Prevention, and Acute and Communicable Disease Program. <http://www.oregon.gov/DHS/ph/odpe>

National Center for Health Statistics

The National Center for Health Statistics (NCHS) is the Nation's principal health statistics agency. NCHS collects data from birth and death records, medical records, interview surveys, and through direct physical exams and laboratory testing to guide actions and policies with the aim of improving the health of residents of the United States. NCHS is a key element of the national public health infrastructure, providing important surveillance information that helps identify and address critical health problems. <http://www.cdc.gov/nchs/hus.htm>

Portland State University, Population Research Center

The Population Research Center began in 1956, initiated by the State of Oregon with the purpose to prepare annual population estimates for cities and counties in order to distribute state tax revenues. The original program was transferred in 1965 to Portland State University, where it has taken on additional duties including the Oregon State Data Center, the lead agency in the state for relationships with the U.S. Census Bureau. <http://www.pdx.edu/prc>



DESCHUTES COUNTY HEALTH REPORT



Services and Information



Clinic Services

Family planning
Sexually transmitted disease
Teen pregnancy prevention

Communicable Disease

Immunization, communicable disease epidemiology, HIV testing, counseling, case management, Emergency preparedness

Women, Infants and Children Program (WIC)

Nutrition counseling
Breastfeeding promotion and education
Maternity case management
Prenatal care, home visiting nurses

Maternal and Child Health Services

Maternity case management
Visiting nurses
Well child clinics
Prenatal care

Prevention and Education Programs

Tobacco prevention and education
Breast and cervical cancer program
HIV prevention and testing
Chronic Disease Prevention
Community Wellness

To download a copy of this report, visit: www.deschutes.org/healthreport

HEALTH DEPARTMENT CONTACT INFORMATION

Bend

Health and Human Services Building
2577 N.E. Courtney Drive
Bend, Oregon 97701
541-322-7400

Downtown Health Center

(Serving young adults through age 25)
1128 NW Harriman
Bend, Oregon 97701
541-322-7457

Redmond

Becky Johnson Center
412 S.W. 8th Street
Redmond, Oregon 97756
541-617-4775

La Pine (Thursdays only)

La Pine Community Campus
51605 Coach Rd.
La Pine, Oregon 97739
541-322-7400

Health Department Website

www.deschutes.org/health

Communicable Disease Reporting

541-322-7418

MISSION STATEMENT

The mission of Deschutes County Health Department is to promote and protect community health and safety through assessment, collaboration, policy development, education, prevention, and the delivery of compassionate care.

Public Health Director

Daniel Peddycord, BSN, MPA/HA

Medical Directors

Mary Norburg, M.D.
Stephen Knapp, M.D.
Richard Fawcett, M.D.

Public Health

Advisory Board Members

Chair: Michael Bonetto, Ph.D., MPH, MS

Vice-Chair: James Rizenthaler, M.D.

Secretary: Nancy Knoble, B.S.

Valle Nazar-Stewart, Ph.D.

Harold Kemple, DDS

Pete Mellinger, Ph.D.

Mary Jeanne Kuhar, M.D.

Aylett Wright, B.A.

Richard Miller, M.D.

Craig Bennett, M.D.

Nancy Ruel

Top Ten Public Health Achievements - U.S.

- Vaccination
- Motor-vehicle safety
- Safer workplaces
- Control of infectious diseases
- Decline in deaths from coronary heart disease and stroke
- Safer and healthier foods
- Healthier mothers and babies
- Access to family planning
- Fluoridation of drinking water
- Recognition of tobacco use as a health hazard

Source: *Morbidity and Mortality Weekly Report*; April 02, 1999; 48(12): 241-243