

Coos County Public Health

Annual Plan

2009-2010

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**Coos County Public Health
Annual Plan 09/10**

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Executive Summary

Coos County Public Health continues to provide the 5 essential services required by Oregon law to meet the health needs of the community. Through these mandated services, we are addressing important social and health problems and state benchmarks: teen pregnancy prevention, child abuse prevention, adequate prenatal care, adequate immunizations for children, protection from communicable diseases, and assurance of safe food and drinking water for the public. We also record vital statistics and provide health information and referral sources. We have set goals and action plans for the 5 basic services and have also included an additional action plan to address emergency preparedness. Completion of these plans as submitted, and provision of services is contingent upon the receipt of adequate funding from the state and federal government.

Health indicators reveal our challenges: Coos County has about the worst poverty rate in the state; a child abuse rate that has decreased but is still too high; the highest rate of inadequate prenatal care in the state; the highest rate of lung cancer in the state and some of the highest rates of smoking for both adults and children. Our nursing staff responded to 555 reports of communicable disease last year, including 10 possible cases of tuberculosis. No active cases of TB were found, although 5 cases proved to be latent TB. The most common communicable disease continues to be Chlamydia, a sexually transmitted infection. We continue to have cases of Meningococcal disease and Pertussis in children and young adults; this requires quick public health response to prevent others from getting sick.

We are seeing some progress in our immunization rates and our teen pregnancy rates are dropping, in part due to the Family Planning Expansion project. Families served in our maternal child health home visiting programs have been helped by our expert staff, although we have had to discontinue our maternity case management home visits due to insufficient funding. Our WIC program is serving an increasing number of women and children (over 3000 annually) to help them get the nourishment needed for proper development. We are seeing increased compliance in many of the public water systems that we monitor, and we have begun to address water quality issues in some of the non-compliant smaller "state" systems which recently came under public health jurisdiction. We continue to work with our emergency preparedness partners to improve our response plans for pandemic illness and natural disasters.

Our budget is projected to be \$2.234 million for FY 2009/10. We expect to carry out our public health mission with the work of 26.45 FTE dedicated staff. We have eliminated 10 positions (including 6 nurse positions) since FY 2006/07, due to the threatened loss of federal timber payments and the reduction in County general fund support. The loss of these positions has compromised our ability to respond to public health emergencies, such as a swine flu epidemic. If there is continued erosion of financial support for public health from the state, it will likely mean that Coos County citizens will not get the public health services and protection that is assured in Oregon law. Meanwhile, our highly trained and capable employees continue to assist many individuals and our whole community, as we work within the limitations of our resources.

Public Health Indicators in Coos County

Note: This following information is reprinted from the Coos County Annual Report 2007-2008, which is found on the website, www.co.coos.or.us.

The **63,210** persons living in Coos County on the southern Oregon coast have a **median age of 45.5 years**. (U.S. 35.3) Residents in this mostly rural county live as part of one of the seven communities spread over **1629** square miles. In 2007, Coos County's ethnicity was comprised of:

- **92.8%** white, or **89.8%** white non-Hispanic,
- **4.5%** Hispanic or Latino,
- **2.7%** Native Americans,
- **1%** Asians,
- **0.5%** Black or African Americans, and
- **0.2%** Hawaiian/Pacific Islanders.

The largest population centers are the adjacent communities of Coos Bay (16,670) and North Bend (9,855), which border the largest deep-water port on the Oregon coast. The rich ocean and lush forests once supported thriving commercial fishing and timber harvesting industries whose importance to the economy has declined. Seasonal jobs dependent on tourism have replaced many family wage jobs.

Income

- The per capita income (2006) was **\$27,269** (State: \$34,247), with an inflation adjusted median household income (2005) of **\$35,195** (State: \$45,721). For comparison, median household income for Coos County in 1999 was \$39,256 (State \$50,922)
- **19.6%** of the population lives below the poverty line (2005) (State: 14.1%).
- The county ranked **34th**, as one of the worst in the state, for poverty (overall). (Oregon Progress Board, 2005).
- As of January 2008, **8.5% (or seasonally adjusted 7.6%)** of adults in Coos County were unemployed. (State: 6.2, seasonally adjusted 5.5)

Health Insurance

- As of May, 2008 **13.6%** of the population was enrolled in the Oregon Health Plan (Medicaid).
- **53.9%** of the birth deliveries in the county in 2007 were paid by the Oregon Health Plan (40% statewide).
- On the Oregon Healthy Teens survey for 2005-2006, **21%** of eleventh graders reported physical health care needs that had not been met in the previous 12 months, because of financial restraints. The 2000 census showed that **14.6%** of the population of Coos County had no health insurance compared to 13.5% in Oregon, and **12%** of children under age 18 in our county had no health insurance compared to 11% statewide.

Public Health concerns in Coos County have multiple causes and are related in part to poverty, socioeconomic conditions, our aging population, the environment, and behavioral factors. Some major issues are:

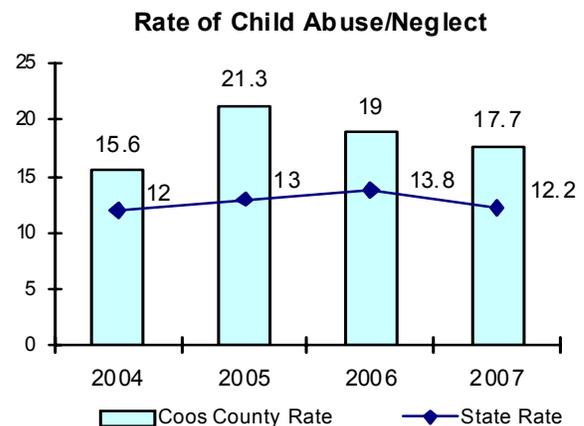
ALCOHOL AND DRUG USE: On the 2005-2006 Oregon Healthy Teens survey (OHT), **35%** of 8th graders and **42.6%** of 11th graders reported having consumed beer, wine or hard liquor in the previous 30 days. Amongst 11th graders, **26.3%** reported having 5 or more drinks in a short period of time during the last 30 days. On the OHT survey, **17.7%** of eighth graders and **26.4%** of 11th graders reported use of illicit drugs during the past 30 days. Less than 1% have used methamphetamines.

CANCER: Figures for 1996-2005 show an annual percentage change of -1.4 over the 10 year period. As of 2005, Coos County has the highest age adjusted rate of all cancer incidence in the state at **539** per 100,000 population. (State: 478) Much of this is a consequence of historically high smoking rates. All the following rates are age adjusted for Coos County:

- Achieved age adjusted cancer mortality rates of **231** (State: 198), ranking second in the State.
- Ranked **highest** in the State for incidence of lung cancer at **92.9** per 100,000 (State:70.3) and **highest** for lung cancer deaths at **79.5** per 100,000 (State:57.2).
- Ranked **3rd** in the State for age adjusted rate of malignant melanoma with a rate of **28.3** per 100,000. (State 22.7; Douglas and Deschutes were 1st and 2nd.)
- Ranked **2nd** for oral and pharyngeal cancer with an average yearly rate of **14.4** per 100,000 (State: 11.2).
- Had the **14th** highest rate of breast cancer, at **135.1**, similar to the State levels of 139.9 for an annual percentage decline over 10 years of -2.7.
- Was **30th** in the state for colon and rectal cancer incidence at **44.8** (State: 48.9).
- Had the **11th** highest incidence rates of **175** (State: 157.8) for prostate cancer, with age adjusted mortality of **26** (State: 30.7) which was the 30th highest prostate cancer mortality rate in the state, showing an annual percentage decline in mortality of -23.5 per year.

CHILD ABUSE: Coos County's rate of child abuse and neglect has declined over the last 3 years. The Coos rate in 2007 was **17.7** per 1,000 children (state rate, 12.2). Coos was ranked 11th (highest) of the 36 counties for victims of abuse/neglect. In 2007, there were **296** incidents (227 children) of child abuse and neglect and **118** foster care entrants in Coos County, compared to 245 children and 136 foster care entrants in 2006 respectively. Most of the abuse in Coos was characterized as *threat of harm* and *neglect*, with younger children being most affected.

The high rate of child abuse and neglect is usually attributed to the high rates of several stress factors, including drug and alcohol abuse, parental involvement with law enforcement, domestic violence and unemployment. In Oregon, mothers were involved in the abuse/neglect **44.6%** of the time, fathers **29.6%** of the time, stepfathers **4.2%** of the time, and live-in companions **5.2%** of the time. The major reasons for placement in foster care were drug and alcohol abuse, physical abuse, neglect, the child's behavior, inability to cope, and inadequate housing.



CHRONIC DISEASE: Asthma continues to present a health burden to residents of Coos County with a population prevalence of **8.7%** as measured by a combined 2002-2005 survey. This means over **5600 people in Coos County suffer from asthma**. The State asthma prevalence is 9.9%. The asthma rate for the Medicaid population is more than double that of privately insured persons. Of Oregon counties, Coos County has the **3rd** highest rate of hospitalization for asthma, at **13.5** per 10,000 residents, with a total of **438** hospitalizations for asthma from 2001-2005.

Data from the 2002 to 2005 Behavioral Risk Factor Surveillance System surveys show that **26.9%** of adult Oregonians suffered from diagnosed **arthritis** and another **22%** had chronic joint symptoms that were not formally diagnosed as arthritis. Coos County's age adjusted rate was **26.4%**. (**unadjusted was 31.4%**) Arthritis is the leading cause of disability in the U.S.

The **death rate from diabetes** in Coos County is **33.2** per hundred thousand compared to 27.7 for the state. Diabetes provides a significant contribution to poor health in Coos County. The **diabetes rate in Coos County at 8%** is about 30 percent higher than the state rate. It is estimated that 2.4% of the residents have undiagnosed diabetes. This means that currently well over 10.7%, or 6700, of the people in Coos County have diabetes. This number is expected to grow markedly as a result of our high rates of smoking and obesity. Smoking a pack of cigarettes a day is associated with a 61% increased risk of diabetes.

Cardiovascular disease is the number one cause of death in Coos County. From 2002-2005, the death rate from heart disease for the Coos County was **226.3** per 100,000 (State: 191.8). The rate of deaths from strokes was 66.4 (State: 68.8). In 2002 heart disease and stroke combined accounted for **35%** of the total deaths. In Coos County, **5%** of the population has suffered from heart attack, **7%** from coronary heart disease, and **3%** from stroke. Statewide, the prevalence rate for heart attack is about 4%, the rate for coronary heart disease is about 4% and the rate of stroke is 2%.

COMMUNICABLE DISEASE: Chlamydia remains the most common reportable communicable disease in Coos County with **88** new cases in FY 2007-2008. There were **3** new cases of gonorrhea, and no new cases of syphilis. Other reportable diseases include: **8** new confirmed cases of salmonella; **1** confirmed case of meningococcal disease; and no active cases of tuberculosis.

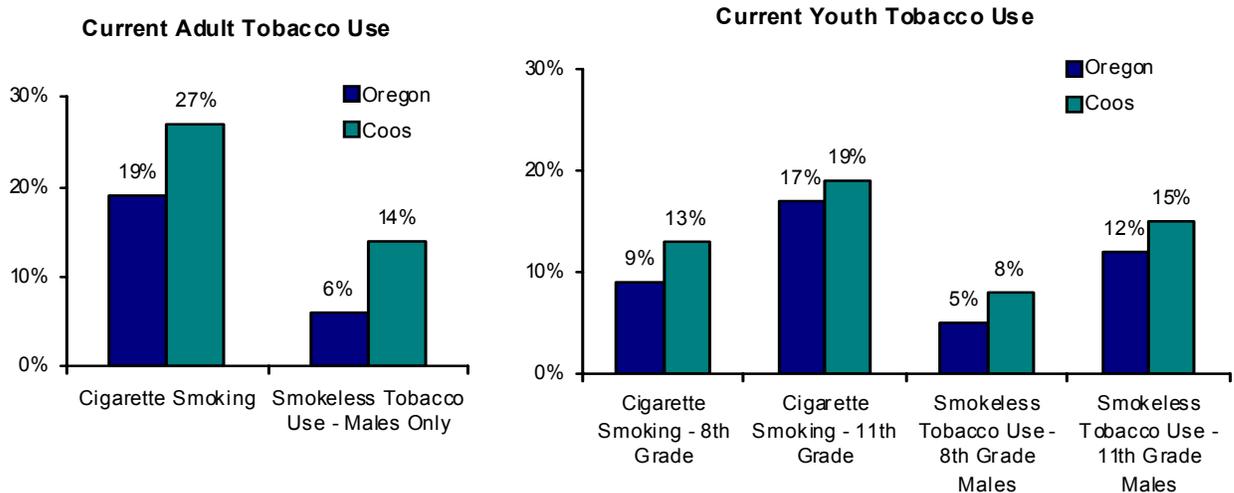
Environmental Health Issues:

- On **14** separate occasions alerts were issued for bacteria in public water systems used for drinking water.
- **1** boil water notice for a community water system used for drinking water was issued.
- **4** health advisories (ranging from 1-20 days) discouraged recreational water contact on two ocean beaches as a result of elevated bacteria levels.
- **4** municipal sewage treatment systems reported outflows of untreated sewage into fresh water.
- **1 new property was added to the "unfit for use list"** due to methamphetamine drug lab contamination, while 2 were removed from the list following clean up.

HUNGER: Hunger is most often a direct consequence of poverty. The Coos County poverty rate was **20%** in 2005 compared to a State rate of 14%. Coos County had the third highest poverty rate in the State. The poverty rate for children under 18 in 2005 was 27.3%. Families with poverty level incomes in Coos County could only afford about half of a basic family food budget. In our county, **15.4%** of the population received Food Stamps and **48.2%** of school children qualified for Free and Reduced Lunch Programs. Single women with children made up about 6% of the families. Single mothers had a **38.7%** poverty rate. Eleven percent of eighth graders reported that they or their family members skip meals or eat less because of financial constraints.

OVERWEIGHT AND OBESITY: Obesity has become the second most important preventable cause of disease, disability and death after smoking. The latest reported figures (2002 to 2005) indicate **38.6%** of Coos County adults are overweight and **23.6%** are obese compared to 37.0% and 22.1% respectively for the State. **12.6%** of Coos County 8th graders are overweight and **11.9%** of 11th graders. (2003-05)

TOBACCO USE: In 2007, Coos County has a significantly higher rate of smoking than the state rate for both adults and children.



In Coos County in 2007, **23% of pregnant women smoked**, compared to the State rate of **12%**. The smoking rate in Medicaid clients in Coos County was **39%**. An estimated **26%** of all deaths in our county are smoking related (27% in 2005). The annual death rate from tobacco related diseases in Coos County from 2002-2005 was **243.6** per 100,000, sixth highest in the State. (State: 184.8)

Birth:

Of the total births in 2007 (n= 658), **41.2 % were to unmarried mothers** (state 35.1%). Of the teen births, ages 15-19, **76%** were to unwed mothers; **52.5%** of mothers ages 20-24 were unmarried. Statistically, unmarried women as a group have a greater proportion of low-birth weight babies; are more likely to smoke than married women, and also have lower income.

Of all births, **8%** were to **Hispanic** mothers.

In 2006, the birthrate for teens, ages 15-17 was **21.1** per 1,000, higher than the state rate of 17.7. **In 2007**, the birthrate for teens, ages 15-17 had declined to **12** per 1,000, compared to the state rate of **16.6**.

Rates of **inadequate prenatal care** had declined to 7% in 2002 and then 6.2% in 2003. This reversed in 2004 when the rate moved up to 8.2% and continued to rise in 2005 to 12.7% (State: 5.8%) In 2006, Coos had the highest rate of inadequate prenatal care in the state at 14.6%, compared to the state rate of 6.2%. Data for **2007** shows Coos continuing to have the highest rate of **inadequate prenatal care** in the state, at **15.1%** (state 6.4%). In 2006, the inadequate prenatal care rate of teens, ages 15-19 in Coos was 20.9%, more than twice the state rate for teens of 10.5%. (Inadequate prenatal care is defined as less than 5 prenatal visits or care that began in the 3rd trimester.)

In 2006, the rate for **low birth weight babies** at **6.4 %** was slightly worse than the state rate of 6.1 %, although the **rate for very low birth weight at 4.6** was better than the state rate of 10.4. The Coos County LBW rate for 2007 was **6.8%** (State 6.1%). Compared to infants of normal weight, low birth weight and very low birth weight infants are at increased risk for impaired development and infant death. Smoking during pregnancy is the single greatest risk factor for LBW.

DEATH:

The **infant mortality rate** for Coos is 6.4 (3 yr. average, 2002-05). Coos County has an unfavorable ranking of 20th in the state, compared to the state average of 5.7.

The **leading causes of death in Coos in 2005**, in rank order were:

1. cancer
2. heart disease
3. cerebrovascular disease
4. chronic lower respiratory disease
5. alzheimers
6. unintentional injuries
7. diabetes
8. alcohol induced disease, and
9. arteriosclerosis.

Adequacy of the 5 Basic Services

(Required by ORS 431.416)

1. Epidemiology and control of preventable diseases and disorders

Public Health staff (public health nurses, environmental health specialists, and the health officer) follow up on any confirmed or suspected cases of 42 diseases and 9 other conditions for which medical providers and labs in Coos County are required by law to report to the health department. We coordinate these reports with state public health. We work to identify the cause or source of any outbreak, identify those who have been exposed to communicable disease, provide health guidance and preventive measures, when appropriate and available (e.g., vaccines and medications) and work to prevent the spread or recurrence of disease. Our health department also reports any clients that we have diagnosed in our clinic. Staff in this program provide consultation to health providers in the community and education to the general public on communicable diseases.

Funding is insufficient to have staff dedicated solely to investigation of communicable disease reports. Completion of investigations by Fridays, especially when the case is reported at the end of the week, is an ongoing challenge. Nurses continue to respond to the CD calls and investigations 24 hours a day 7 days a week after hours, with calls relayed through our dispatch 911 service. An updated contact schedule is provided each Friday to dispatch. A large outbreak or public health emergency would require far greater resources than this department has available.

Our department has lost funding that we have had in past years to provide prevention programs for the chronic diseases of diabetes and asthma. We are a contract provider for the breast and cervical cancer screening program. We are pleased to have funding for a tobacco prevention program, as our rates of smoking continue to be higher than the state's rates. We have recently received funding to do community assessment and action planning for "tobacco related and other chronic diseases."

2. Parent and child health services, including family planning clinics (ORS 435.205)

Nurses provide home visitation in Babies First! (aka Parents as Teachers) Healthy Start, and CaCoon programs. All Parent educators (nurses and public health aides) use the Parents As Teachers curriculum. Depending on the specific home visiting program, staff either follow State Commission on Children and Families Healthy Start Policies and Healthy Families America guidelines or Babies First! protocols. We have a limited staff in CaCoon, and we try to stretch our resources to serve the children with special health care needs.

UPDATE: For this coming year, we are projecting to have 2.05 FTE nurses providing services in the home visiting programs, including the manager who supervises the Healthy Start Program at .35 FTE. Additional nurse time is projected to be contracted at .6 FTE to work with DHS's Self sufficiency JOBS Program to help case managers with health assessments. In addition, we will have three full time paraprofessional parent educators, one who works in the Babies First! / Parents As Teachers program and 2 who will work in the Healthy Start program. All aides work under the supervision of a public health nurse.

All Parent Educators provide parent education, advocacy, and support to parents. In addition, we focus on prevention of family violence, prevention of, or intervention for substance abuse, SIDS risk reduction, child nutrition, immunizations, child safety, developmental screening, and case management. All home visitors in the Maternal Child Health Home Visiting programs are supervised by an experienced Public Health Nurse with a Masters in Public Health. All of our home visiting programs are based on best-practice models and work to prevent child maltreatment through the provision of services that strengthen families. Our home visiting programs are highly accessible as we provide services throughout Coos County. Our programs are in demand, and we usually have clients on a waiting list.

Update: Due to the continued inadequate Medicaid reimbursement rates, we are still unable to afford to provide maternity case management home visiting services to pregnant women. We will continue to direct our remaining prenatal funds towards referring expectant mothers to other available services within the county and offering assistance in competing OHP applications through our Oregon Mothers Care program. We will also continue to partner with other agencies interested in improving the perinatal outcomes of pregnant and postpartum women through the Perinatal Task Force.

According to the service data for Oregon Title X Family Planning Agencies, in 2007 there were 2,824 *women in need* (WIN) in our county between the ages of 13 and 44. We served 1,467 of those WIN clients in 2007, or 51%, (compared to 56% the previous year) *State average 2007: 58.5%*). Of the estimated number of teens in need of services ages 15-17, we served 26% (n=222). Our contraceptive services are estimated to have averted 228 pregnancies. The teen pregnancy rate in the county continues to decline after a rise in the previous year.

This past year we received funding for a certified school based health center, located on the Marshfield High School Campus. Public Health was instrumental as a pass through agency for funds to supplement the SBHC budget needs.

3. Collection and reporting of health statistics.

We register all births and deaths in Coos County and forward the information to the state, as required by administrative rules. In addition to the County Registrar, our lead deputy registrar, who is available full time, has backup support from 3 other individuals who serve as deputy registrars.

4. Health Information and Referral Services.

All health department programs provide health information and referrals to programs within our agency and also to outside agencies that can help meet needs that are beyond the scope of our agency. Examples include referring well women over 40 years of age to local resources for primary care, referring a pregnant woman to a medical doctor for prenatal care, referring a young parent for food stamps. Our support staff who answer the main switchboard spend significant time as a referral source. We strive to keep up-to-date on our community resources and our referral lists current. Health education, with a prevention focus, is also a key component of our public health programs.

To enlighten the community about public health services, we continue to publish an annual report, post messages on our electronic sign on the front of the County Annex, send public service announcements regarding services and new developments, post educational bulletins and general information on our newly developed My Space account, speak to groups about “*Public Health in Our Communities,*” upon request, and strive to complete our website.

5. Environmental Health Services

The Environmental Health program licenses and inspects restaurants, motels, RV parks, pools, spas, and organizational camps. Our environmental health specialists teach and certify food handlers and also provide food service manager training. To protect from food-borne illnesses, we license and inspect temporary food events that are open to the public. We also investigate reported cases of food-borne and water-borne illnesses. We monitor small public water systems (this year monitoring will include the additional systems with 4-14 connections) and perform a limited number of septic loan inspections. We also inspect correctional facilities, school kitchens, and daycare centers.

For the on-site sewage disposal system within Coos County, the Oregon Department of Environmental Quality (DEQ) maintains all regulatory oversight. Our department may consider delegation for this function at a future date.

Solid waste is not regulated by this department. Individual cities have independent solid waste ordinances, as does Coos County. Our staff frequently receive nuisance complaints related to illegal dumping and make referrals to the applicable jurisdiction for code enforcement. Privately operated Sanitation/Garbage companies handle the majority of domestic solid waste within Coos County. Beaver Hill Disposal Site is the only solid waste disposal site within the county and is operated by Coos County. Regulatory oversight is provided by the DEQ.

Staff consist of a full time Environmental Health (EH) Specialist trainee and an EH Program Manager, with .9 FTE clerical support.

The following describes the **adequacy of services the Health Department should include or provide for in programs, according to OAR 333-014-0054.**

1. **Dental:** The water system serving our largest populated area has fluoridated water. Many others in our rural county are on small water systems without fluoridation or have private wells. Dental awareness is conducted through WIC and home visiting programs, and nurses conduct visual "lift the lip" exams with children 0-5 during home visits. Care for children's teeth is discussed, and brochures on baby bottle tooth decay and toothbrushes are distributed. The maternal / child health staff are continuing to work with local dentists and community partners to increase access to dental care for pregnant women and children. We share educational resources with the dental hygiene society and provide “lift the lip” screening/referral services to children and parents in Healthy Start, WIC, SSP/TANF, and the Southern Oregon Community College’s Family Center.

2. **Emergency Preparedness:** Our department's role in a declared emergency is to coordinate the health system response throughout the county. In response to a bioterrorist event or other public health emergency, we would also work to protect the public's health by preventing additional exposure to communicable agents and provide counter measures, such as vaccine and antibiotics. Staff have worked with the County Emergency Management staff to update the medical portion of the County's Emergency Response Plan and have drafted the emergency communication plan for the department and the pandemic influenza response plan. We meet monthly with community partners to work on health system issues in emergency response.
3. **Health Education and Health Promotion:** Health education and promotion are components in all Health Department programs. Examples that we will continue to provide include breastfeeding support in WIC; food handler training; parent education for parents of newborns; correct use of child safety seats in vehicles; safer sex practices for persons with HIV.
4. **Laboratory Services:** Our department has a CLIA waived lab, currently licensed as a PPM lab. We provide limited diagnostic and screening tests for our clients in the family planning and sexually transmitted disease programs.
5. **Medical Examiner:** The Medical Examiner in Coos County works out of the District Attorney's office.
6. **Nutrition:** Nutrition education and counseling is the primary focus of the WIC program. Nutrition counseling is also a component in our maternal child services, and family planning services. Funds have not been available to do community-wide promotion activities, e.g., for weight control and prevention of heart disease. Although we expect to include these topics in our community assessment funded by the "tobacco related and other chronic disease" project.
7. **Older Adult Health:** This department provides flu shots and other immunizations to our older population. We currently are a contracted provider for the Breast and Cervical Prevention Program, which serves women (and men) ages 40-64 who meet the eligibility criteria. Our department does not currently have funds to target other important health interventions for elders, such as arthritis and cardiovascular health.
8. **Primary Health Care:** Our department does not provide primary health care. We assist with the application process for the Oregon Health Plan, and we refer to local medical providers, including the local safety net providers in the Waterfall Clinic. We continue to provide limited assistance to persons seeking publicly funded insurance, and prescription assistance. Through Oregon Mothers Care, we help pregnant women get appointments for prenatal care and apply for financial assistance. With the cutbacks on the Oregon Health Plan eligibility, however, the numbers without health insurance are increasing.
9. **Shellfish Sanitation:** Services are provided locally through the Oregon Department of Agriculture (ODA). Commercial shellfish harvesting is regulated by ODA under ORS 622 and standards set by U.S. Food and Drug Administration. ODA provides routine updates to

the public and Coos County Public Health on status of shellfish harvesting in specific coastal areas. If circumstances warrant, Coos County Public Health may take additional steps to alert the public to related sanitation issues.

Action Plans

For

Each of the Five Basic Services

Control of Communicable Disease Action Plan 2009/2010

Current Condition or Problem (Updated):

1. Coos County investigated 555 reports of communicable disease during FY 2007/2008; including the following:

AIDS/HIV – 1 case in 2007, (0 in 2006), (1 in 2005), (4 in 2003)	Hepatitis C – 79 cases, 2007 (191 in 2006), (159 in 2005)
Chlamydia – 86 cases, 2007 (77 in 2006), (115 in 2005)	Pertussis – 0 cases, 2007 (2 in 2006), (5 in 2005)
Gonorrhea – 3 cases, 2007 (2 in 2006), (2 in 2005)	Meningococcal disease – 4 cases, 2007 (5 in 2006), (3 in 2005)
Hepatitis A – 0 cases, 2007 (1 in 2006), (0 in 2005)	Giardiasis – 9 cases, 2007 (14 in 2006), (8 in 2005).
Hepatitis B – 1 case, 2007 (8 in 2006), (7 in 2005)	
2. Coos County Public Health (CCPH) continues to respond to communicable disease calls 24/7. We have trained individuals in basic BT/CD Epidemiology (CD 101), and also CD 303. One Environmental Health Specialist is also trained in CD 101 and 303, and the other EH specialist will also be trained to respond to questions and concerns when it is applicable to their field.
3. Investigations of reportable conditions and communicable diseases are conducted, control measures are carried out, and investigation report forms are completed and submitted as per the Investigative Disease Guidelines.
4. On-going training of staff is aimed at improving our ability to work in coordination with all of our community partners to improve communicable disease response. These partners include, but are not limited to: local hospitals, emergency medical services, fire, police, county emergency management, local volunteer agencies, local CERT teams, and state communicable disease personnel.
5. Immunizations for human target populations, such as those at risk for Hepatitis, are available here in the Health Department. Rabies immunizations for animal target populations are available within our jurisdiction, and rabies treatment inoculations are available locally at Bay Area Hospital.
6. We continue to receive and distribute public health alerts. Information is provided to the local providers via fax broadcast, e-mail and local media. We will continue to test this system periodically to identify any problem areas, and to keep all the contact information updated. This system is also in place for contacting city municipalities, public safety officers (fire & police), and veterinarians.
7. CCPH continues to work closely with Oregon Health Services/ Acute & Communicable Disease Program (OHS/ACD). We have contacted the on-call epidemiologist after working hours on more than one occasion, and have had success using the OHS/ACD paging service.

The epidemiologist on call has returned our call in a timely manner and has been able to assist us in the investigation via telephone consultation.

Goals:

- To continue to be prepared to identify and respond to reports of communicable disease outbreaks 24/7.
- To continue to complete and submit CD investigation documentation within the mandated timelines, > 90% of the time.
- To continue to provide education to the community on protection from potential illness and/or exposures.

Activities:

- Maintain emergency call back of trained CD staff via 911/dispatch service for 24/7 coverage.
- Distribute information received from CDC, Health Alert Network, and other sources to appropriate community partners.
- Continue active & passive surveillance of community illness/reportable diseases and/or syndromes.
- Update the county website with pertinent information on communicable diseases and/or public health preparedness topics, as funding and support permits.
- Train any nurses and new to the department in CD response, and provide continuing education to the public health staff about their duties and responsibilities during a communicable disease outbreak.
- Work with Tribal officials for a coordinated response to outbreak investigations.
- Investigate all reported communicable diseases/conditions within the investigative guidelines.
- Continue to test current communication capabilities, such as fax and email, with all local partners to ensure ability to distribute information during emergency situations.
- Make contact with the local laboratories and infection control practitioners on a periodic basis to encourage reporting.
- Hold additional meetings with Bay Area Hospital department heads (from nursing, medical records, lab, client care supervisor) and public health staff (environmental health, communicable disease nurse, and clinic manager).

Evaluation:

- Meet the performance time lines for investigation and submission of forms to DHS/ACDP.
- Log the number of community outreach activities.
- Tabulate the results of communications testing.

Challenges:

Our cuts in personnel create challenges for meeting the requirements of this contract program element.

Tuberculosis

Action Plan 2009/2010

Current Condition or Problem:

Update: In FY 2007/2008, our nurses investigated 10 possible cases of tuberculosis, of which none were found to be active cases, compared to 2 active cases in the previous reporting period. Latent tuberculosis infection (LTBI) continues to be identified in the county. During the past fiscal year, 5 individuals were diagnosed with latent tuberculosis. Most cases have been identified during testing for purposes such as immigration, employment, and school admission. Nurses performed 91 skin tests for 85 individuals.

Goals:

- Accurately identify active and latent TB cases in the community.
- Ensure that the active tuberculosis cases receive Directly Observed Therapy (DOT), as necessary, for the duration of therapy appropriate to their cases.
- Contact all persons with latent disease to discuss the appropriateness of antibiotic therapy.

Activities:

- Public health nurses and the Health Officer will continue to work cooperatively with Department of Human Services/Health Services and local medical providers to provide evaluation of positive PPD skin tests.
- Provide state supplied medication at no cost to those clients without medical insurance and/or limited resources when appropriate.
- Ensure that follow-up sputum testing is done at the appropriate intervals during treatment of active TB.
- Provide TB testing via the PPD method as requested and provide timely follow-up testing and treatment for any contacts to a person with known or suspected active TB, using the investigative guidelines.
- Submit appropriate completed forms to the state TB division at the initiation of therapy, as further information is available, and at the completion of therapy for both active and latent disease.

Evaluation:

- Timely investigation and identification of index cases and contacts.
- Accurate and complete documentation of completion of treatment and/or case management of clients, according to CCPH protocols.

Challenges:

Provision of DOT to active cases of TB is a challenge due to budget constraints at the local level, and minimal financial support for this work from the state. The state does continue to provide the appropriate medications for treatment of both LTBI and active TB to the county at no cost. The actual cost for follow up and management of active TB cases requiring DOT often exceeds the amount of funding provided. Patients with latent disease are seen and evaluated monthly, requiring allocation of nursing hours, and administrative costs. We will continue to provide services to the best of our ability. However, lack of resources may limit our response capability, eventually, and that will result in a risk to the community. Active tuberculosis, if untreated, could lead to an epidemic with devastating consequences.

Local Health Department: Coos County Public Health

Plan A - Continuous Quality Improvement: 4:3:1:3:3 Immunization Series Coverage Rate

Fiscal Years 2007-2010

Year 1: July 2007 – June 2008		
Objectives	Methods / Tasks	Outcome Measure(s)
<p>A. Increase the 4:3:1:3:3 immunization series coverage rate by 1% and decrease the missed shots rate by 1%</p>	<ul style="list-style-type: none"> • Quarterly reminders will be mailed to the parents of children 12-35 mo. who are due for a 4th DTaP and children 2-35 mo. who are late starters (received their first shot after 3 months of age). • Use IRIS and ALERT to forecast. Recommend to parents that the child receive all shots due at the time of visit. • Assess the 4:3:1:3:3 immunization rates annually. • Assess the missed shots rate annually. 	<ul style="list-style-type: none"> • Reminders will be sent by the last business day of the quarter (i.e. Sep 30). • With each visit, an IRIS and ALERT forecast will be printed 100% of the time for children 2 years of age and younger. • The 4:3:1:3:3 immunization rates will increase by 1%. • The missed shots rate will decrease by 1%.

Outcome Measure(s) Results	Progress Notes
<ul style="list-style-type: none"> • Reminders sent: <p>First quarter – 32 reminders sent on 9/21/07 for the 4th DTaP due. 7 reminders sent on 10/7/07 for late starters due for a DTaP.</p> <p>Second quarter – 31 reminders sent on 1/11/08 for children 12-35 months due for a DTaP.</p> <p>Third quarter – 20 reminders sent on 4/8/08 for children <35 months of age due for a DTaP</p> • IRIS and ALERT forecasts are printed at 100% of visits for children 2 years of age and younger. • The 4:3:1:3:3 rate increased from 69% in 2006 to 76% in 2007 • The missed shots rate decreased from 16% in 2006 to 15% in 2007. 	<p>During the end of the 1st quarter, there were problems retrieving the 4th DTaP report from IRIS. An IRIS 4th DTaP report was finally obtained from IRIS on 9/21/07. A list of “late starters” was received from ALERT in October. The list was largely children with a status of “WIC Only”. After excluding the “WIC Only” children, reminders were sent for “late starters” who were due for a DTaP.</p> <p>At the end of the 2nd quarter, there were problems retrieving the IRIS 4th DTaP report and data was unable to be obtained. A list of “late starters” was received from ALERT on 12/4/07. The list only had children with a status of “Active”, but should also have included children with a status of “Change in medical home, Provider pending, etc. On 1/2/08, a second report was received from ALERT with children 12-35 months of age due for a DTaP.</p> <p>For the 3rd quarter, a list of children less than 35 months due for a DTaP and “late starters” due for anything was received from ALERT on 4/8/08. There are children on the 2nd quarter list who did not return for their DTaP, but were not included on the 3rd quarter list.</p> <p>In order to reach this objective, the list received from ALERT must include children with the same status and age groups as the list of children used for the <i>Annual Assessment of Immunization Rates and Practices</i>. This will ensure that reminders are sent to the same children which the <i>Annual Assessment of Immunization Rates and Practices</i> data will reflect at the end of the year. Coos County Public Health continues to work with ALERT to obtain the appropriate list of children each quarter.</p> <p>Even with the difficulty in obtaining reports of children due for a DTaP, Coos County Public Health was able to increase the 4:3:1:3:3 rate and decrease the “missed shots” rate.</p>

Local Health Department: Coos County Public Health

Plan A - Continuous Quality Improvement: 4:3:1:3:3 Immunization Series Coverage Rate

Fiscal Years 2007-2010

Year 2: July 2008-June 2009		
Objectives	Methods / Tasks	Outcome Measure(s)
<p>A. Increase the 4:3:1:3:3 immunization series coverage rate by 1% and decrease the missed shots rate by 1%</p>	<ul style="list-style-type: none"> • Quarterly reminders will be mailed to the parents of children 12-35 mo. who are due for a 4th DTaP and children 2-35 mo. who are late starters (received their first shot after 3 months of age). • Use IRIS and ALERT to forecast. Recommend to parents that the child receive all shots due at the time of visit. • Assess the 4:3:1:3:3 immunization rates annually. • Assess the missed shots rate annually. 	<ul style="list-style-type: none"> • Reminders will be sent by the last business day of the quarter (i.e. Sep 30). • With each visit, an IRIS and ALERT forecast will be printed 100% of the time for children 2 years of age and younger. • The 4:3:1:3:3 immunization rates will increase by 1%. • The missed shots rate will decrease by 1%.

Outcome Measure(s) Results	Progress Notes
<ul style="list-style-type: none"> • Reminders were sent via the IRIS postcard system. • When both the IRIS and ALERT systems were available, forecasts were printed at every visit for children 2 years of age and younger. • The 4:3:1:3:3:1 immunization rate decreased from 76% in 2007 to 71% in 2008. • The missed shots rate decreased from 15% in 2007 to 8% in 2008. 	<p>In September 2008, Coos County Public Health requested a list from ALERT of children 12-35 months who were due for a 4th DTaP and children 2-35 months who were “late starters. Coos County Public Health was informed that ALERT staff no longer had time to pull extra reports of shots due and to rely on the IRIS postcards for reminders. At that time, Coos County Public Health was still unable to pull a “4th DTaP Due” report from IRIS.</p> <p>On 3/18/09, Coos County Public Health was able to pull the “4th DTaP Due” report from IRIS and 19 reminder postcards were mailed.</p> <p>On 4/3/09, Coos County Public Health was notified that postcards from IRIS had not gone out for the previous 3 months.</p> <p>On 4/8/09, Coos County Public Health was notified that the IRIS system was down. IRIS forecasts have not been able to be obtained since then. ALERT forecasts continue to be printed at 100% of visits for children 2 years of age and younger.</p> <p>With the difficulty in obtaining a list of children to send additional reminder postcards, the 4:3:1:3:3:1 rate decreased by 4%. Coos County Public Health was able to improve the “missed shots rate” by 7%.</p>

Local Health Department: Coos County Public Health

Plan A - Continuous Quality Improvement: 4:3:1:3:3 Immunization Series Coverage Rate

Fiscal Years 2007-2010

Year 3: July 2009 – June 2010				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p>A. Increase the 4:3:1:3:3 immunization series coverage rate by 1% and decrease the missed shots rate by 1%</p>	<ul style="list-style-type: none"> Quarterly reminders will be mailed to the parents of children 12-35 mo. who are due for a 4th DTaP and children 2-35 mo. who are late starters (received their first shot after 3 months of age). Use IRIS and ALERT to forecast. Recommend to parents that the child receive all shots due at the time of visit. Assess the 4:3:1:3:3 immunization rates annually. Assess the missed shots rate annually. 	<ul style="list-style-type: none"> Reminders will be sent by the last business day of the quarter (i.e. Sep 30). With each visit, an IRIS and ALERT forecast will be printed 100% of the time for children 2 years of age and younger. The 4:3:1:3:3 immunization rates will increase by 1%. The missed shots rate will decrease by 1%. 		

Local Health Department: Coos County Public Health
Plan B - Chosen Focus Area: AFIX Exchange Luncheon
 Fiscal Years 2007-2010

Year 1: July 2007 – June 2008				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p>A. Educate public and private providers on ways to increase immunization coverage rates.</p>	<ul style="list-style-type: none"> • Assist with the annual AFIX Exchange Luncheon to be hosted by the DHS IZ program AFIX team. • Staff from all private and public clinics that provide immunizations will be invited to attend the AFIX Exchange Luncheon. 	<ul style="list-style-type: none"> • The annual AFIX meeting will be held in the Spring 2008. • There will be attendance from Bay Clinic, NBMC-Bandon, NBMC-Coos Bay, NBMC-Coquille, NBMC-Myrtle Point, Coquille Indian Tribe, Powers Clinic, Waterfall Clinic and Marshfield SBHC. 	<ul style="list-style-type: none"> • The annual AFIX meeting will be held May 6, 2008. • Invitations were mailed to Bay Clinic, NBMC-Bandon, NBMC-Coos Bay, NBMC-Coquille, NBMC-Myrtle Point, Coquille Indian Tribe, Powers Clinic, Waterfall Clinic and Marshfield SBHC. 	

Local Health Department: Coos County Public Health
Plan B - Chosen Focus Area: AFIX Exchange Luncheon
 Fiscal Years 2007-2010

Year 2: July 2008 – June 2009				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p>A. Educate public and private providers on ways to increase immunization coverage rates.</p>	<ul style="list-style-type: none"> • Assist with the annual AFIX Exchange Luncheon to be hosted by the DHS IZ program AFIX team. • Staff from all private and public clinics that provide immunizations will be invited to attend the AFIX Exchange Luncheon. 	<ul style="list-style-type: none"> • The annual AFIX meeting will be held in the spring 2009. • There will be attendance from Bay Clinic, NBMC-Bandon, NBMC-Coos Bay, NBMC-Coquille, NBMC-Myrtle Point, Coquille Indian Tribe, Powers Clinic, Waterfall Clinic and Marshfield SBHC. 	<ul style="list-style-type: none"> • The annual AFIX will be held April 30, 2009. • Invitations were sent to Bay Clinic, NBMC – Bandon, NBMC – Coos Bay, NBMC – Coquille, NBMC – Myrtle Point, Coquille Indian Tribe, Powers Clinic, Waterfall Clinic and Marshfield SBHC. 	

Local Health Department: Coos County Public Health
Plan B - Chosen Focus Area: AFIX Exchange Luncheon
 Fiscal Years 2007-2010

Year 1: July 2009 – June 2010				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p>A. Educate public and private providers on ways to increase immunization coverage rates.</p>	<ul style="list-style-type: none"> • Assist with the annual AFIX Exchange Luncheon to be hosted by the DHS IZ program AFIX team. • Staff from all private and public clinics that provide immunizations will be invited to attend the AFIX Exchange Luncheon. 	<ul style="list-style-type: none"> • The annual AFIX meeting will be held in the Spring 2010. • There will be attendance from Bay Clinic, NBMC-Bandon, NBMC-Coos Bay, NBMC-Coquille, NBMC-Myrtle Point, Coquille Indian Tribe, Powers Clinic, Waterfall Clinic and Marshfield SBHC. 		

Increase Access to Early and Adequate Prenatal Care Action Plan 2009/2010

Current Condition or Problem:

In 2007, 15.1% of pregnant women in Coos County received inadequate prenatal care (defined as fewer than 5 visits before the third trimester), compared to the state rate of 6.4%. In 2007, 69.8% of all pregnant women in Coos County received prenatal care in the first trimester compared to the state rate of 79.2.

Early prenatal care is important because:

- Complications to mother or fetus can be identified early and managed.
- There is adequate time to make referrals to smoking/drug/alcohol cessation programs, as substance use has been associated with low birth weight babies, preterm labor, sudden infant death syndrome, stillbirths, ectopic pregnancies, fetal alcohol syndrome, birth defects, and other conditions.
- Existing medical problems, such as hypertension and diabetes, can be better managed. (If uncontrolled, these have been associated with poor pregnancy outcomes for both mother and fetus.)
- It allows time to address psycho-social issues and make referrals to other agencies such as WIC, DHS-SSP, and the Housing Authority, to address a client's basic needs.

Update: Due to inadequate Medicaid reimbursement rates, Coos County Public Health no longer offers home visiting services to pregnant women through the Healthy Beginning program/Maternity Case Management. Instead, our efforts have shifted towards working with community partners to help identify and reduce barriers to receiving adequate and/or early prenatal care. We have received a grant through the Commission on Children and Families to perform a community needs assessment to assist us with identifying these barriers. In the past, identified barriers have included the following:

- Denial of pregnancy or lack of recognition of pregnancy until later into the gestational period
- Procrastination
- Low education levels
- No medical insurance
- Ignorance of the Oregon Health Plan requirements and difficulty with the application process
- Drug/alcohol issues
- Language barriers for Spanish speaking population (difficulty applying for OHP, communicating with prenatal care providers, few materials translated, few staff who speak Spanish)
- Mental health issues/conditions
- Previous involvement with Child Welfare Protective Services

We anticipate that our community assessment will be in agreement with these historical barriers as well as identify additional barriers. Further access problems to prenatal care that have been identified in the past include:

- Lack of prenatal care providers in areas outside North Bend/Coos Bay; lack of prenatal care providers who speak Spanish.
- Lack of transportation to medical services, especially with the decrease in frequency of bus routes/stops.
- Late (after the first trimester) referrals to the Health Department for Maternity Case Management (MCM) and other services by other community providers.
- Lack of smoking cessation support groups
- Lack of easy access and treatment for dental care during pregnancy

Goals:

- Continue to be an active participant in the Coos County Perinatal Task Force to identify perinatal issues and solutions that help to improve outcomes for both mother and baby
- Refer pregnant women to locally available services
- High level outcome: **Strong nurturing families and healthy thriving children.**

Activities:

- Assist pregnant clients with applications to the Oregon Health Plan and facilitate pregnant women's first appointments with prenatal care providers, through the Oregon Mother's Care (OMC) Program.
- Refer pregnant clients from internal Public Health Department programs such as WIC and pregnancy testing to Oregon Mothers Care (OMC) and outside agencies which provide support during the prenatal period such as The MOMS program through Bay Area Hospital, Coquille Valley Hospital's perinatal outreach program, and Pregnancy Resource Center.
- Continue to meet monthly and work with the Perinatal Task Force (PNTF) to assess and plan ways to improve the early prenatal care rates in Coos County. The PNTF includes representatives from Bay area Hospital, Public Health, DOCS – Independent Practice Association, A & D treatment, DHS Food Stamps/Temporary Aid to Needy Families, and physicians and other organizations.
- Continue to assist with the Perinatal Task Force's new perinatal depression group, "Parenting Survival Skills: Adjusting to Your New Baby," that provides 4 weeks of education to pregnant and postpartum mothers, and a follow-up support group.
- Continue to meet with the Coos County Breastfeeding Coalition.
- Encourage state nursing consultants to work with OMAP and other policy makers to increase MCM reimbursement rates, considering that service to an MCM client actually is benefiting the health and wellness of 2 clients (mother and unborn child).

Evaluation:

- Number of pregnant women served through Oregon MothersCare who have successfully initiated prenatal care
- Log of the number of community outreach activities

Challenges:

- The state support for perinatal services is insufficient for the number of women who can be served with Maternity Case Management
- The Medicaid reimbursement rate for MCM services does not reflect the actual cost of providing these services. Lack of financial support has resulted in our phasing out this crucial service.

Infants and Children Will Have Nurturing Caregivers & Decreased Child Abuse Action Plan 2009/2010

Current Condition or Problem:

Update: The 2007 statistics for child abuse showed that Coos County is now ranked 14th in the state (an improvement from 7th in the state) with a rate of 17.7 per 1000, down from 19.0 per 1000 in 2006. The state rate is 12.2 per 1,000. Major family stressors that contribute to Coos County's child abuse/neglect rates are drug and/or alcohol abuse, parental involvement with a law enforcement agency, unemployment, and domestic violence. Other contributing factors are: low income, limited education, and poor parenting (the most prevalent factor according to the Child Welfare System). However, poor parenting is often generational and may be influenced also by the factors listed above. The major reasons for placement in foster care were threat of harm, drug and alcohol abuse, physical abuse, neglect, the child's behavior, inability to cope, and inadequate housing.

One participant in our Babies First! (Parents As Teachers) program stated:

"I am pleased that programs like this exist because I need all the help I can get when it comes to parenting. I am a single mother with a small child and the skills that I have learned will make our lives better, healthier, and happier. Thank you!"

Update: The following statistics reflect a sampling of the children served in our Babies First (Parents As Teachers) and CaCoon programs for the 2007-2008 fiscal year:

- 100% of parents stated their needs were identified
- 100% of parents stated their parent educator helped them understand how their child grows and develops
- 100% of parents stated they felt comfortable discussing their concerns with their parent educator
- 91% of parents stated they felt more confident as parents
- 100% of parents stated their parent educator connected them to useful resources
- 93% of parents stated their parent educator helped them strengthen their relationship with their child
- 100% of parents stated their parent educator helped them learn and use positive discipline methods

Goals:

- Reduce child abuse and neglect.
- High level outcome: **strong nurturing families and healthy thriving children.**

Activities:

Research shows that early intervention into the lives of families, beginning in and including the prenatal period, has a high impact on parental success and lessens child maltreatment.

- Provide regularly scheduled home visits through the **Babies First! (formerly known as Parents As Teachers or PAT)** program for children at risk of developmental delay due to a variety of risk factors including: premature birth; drug exposed infant during pregnancy; low birth weight; age of the parent/caregiver; low income/ poverty and many other factors. **Babies First!** targets children from birth through age four. Potential problems can be detected quickly and interventions started and monitored regularly. Public health nurses conduct in-home health and developmental screening for participating children on a regular basis. The nurses work closely with the families on parenting skills, health education, advocacy, and referrals to services in other agencies. **Babies First!** focuses on helping families learn to care for and better understand their children. Case management activities help link families to needed community resources and providers. Using the Parents As Teachers best practice curriculum, and following the Babies First protocols, nurses and public health aides (under the supervision of a nurse) help parents learn positive parent-child interactions, child development, realistic expectations, and coping skills. This parenting program provides information and guidance to reduce child abuse and neglect and promote “readiness to learn.” During the visits, educators help parents understand what to expect in each stage of their child’s development, and offer practical tips on ways to encourage learning, manage challenging behavior, and promote strong parent-child relationships. Screening is done for overall development, language, hearing, and vision. Case management activities help link families to needed community resources and providers.
- Provide nursing case management for children with special health care needs through the **CaCoon** program. Nurses assist parent with medical, nutritional, and developmental issues and promote positive coping skills. Parents are helped to identify and prevent problems related to their child’s special health condition. Screening is done for growth and development and referrals are made into early intervention when needed. Nurses also coordinate health care and specialty services. CaCoon Nurses will participate in Community Connections as needed and as able, considering the limitations of funding.
- Provide the **Healthy Start** program to first time families identified as eligible to receive intensive home visiting Healthy Start services. This program was transferred to CCPH in fiscal year 06-07. Policies and procedures have been developed that adhere with the state Healthy Start policies and procedures, Healthy Families America best practice guidelines, and state/county CCF protocols. This program fits well into CCPH’s existing continuum of home visiting programs.
- Continue to assist with the perinatal depression group, “Parenting Survival Skills: Adjusting to Your New Baby,” which was formed through a collaborative effort of our local Perinatal Task Force. The depression group consists of a 4 week curriculum that is then followed by a support group for those who have graduated from the class. Since research shows that new moms who have a history of depression often miss or

misinterpret their babies' cues, this intervention for the mothers' depression can be important for the ultimate development of positive mother/child attachments.

- Continue to participate in the Coos County Breastfeeding Coalition to promote breastfeeding and improve breastfeeding rates among county residents.
- Continue to partner with CWS, Coos Bay/North Bend Rotary, and Bay Area Hospital (through their Community Development Grant) to provide parenting education services to families who may not be eligible for Targeted Case Management billing.
- Continue to develop rapport with local and regional dental community to improve access and treatment of pregnant women and young children to promote early childhood cavities prevention.
- **Update:** Work with the Dental Outreach of Oregon (a joint cooperation group comprised of Oregon's four managed dental care plans) to develop a no cost dental hygiene program targeting pregnant women and children under the age of 5 years old. Services would include oral health screenings, prophylaxis, fluoride varnish applications, and referrals to dental homes for additional services through a contract with an LAP hygienist. Education and prevention care will be the focus of the project.
- Continue to seek funding opportunities through grants and/or contracts to help support our maternal child health services.
- Work with regional dental consultants to possibly plan for setting up a dental clinic to assess our Family Health home visiting clients as well as WIC clients.
- The Nursing Services Manager will continue to participate in local MDT and Child Fatality Review Board.
- Maternal Child Health staff will continue to participate in DHS: Child Welfare Services's System of Care meetings, Family Decision Meetings, etc. as appropriate.
- Maternal Child Health staff will continue to participate in Family Violence Council meetings.
- Continue to be active participants on the Coos County *Zero to Three Court Team* pilot program, providing administrative support as well as direct services to enrolled families via our Healthy Start, Babies First! and CaCoon programs.
- Consider sending the Maternal Child Health Home Visiting Supervisor or other delegate to "Circle of Security" training to then be able to provide more in depth training to remainder of staff on issues related to attachment.
- Plan on sending at least 1-2 field staff to annual Child Abuse Summit, if funding available.
- Continue to offer in-service trainings to staff, on topics such as domestic violence, child abuse, and infant-toddler mental health.

Evaluation:

For families served by **Babies First! (Parents as Teachers):**

- Families needs will be identified in 100% of clients.
- 80% of parents will demonstrate positive child-rearing competencies and improved parenting skills
- 80% of parents will demonstrate positive parent-child interactions.
- 80% of parent s will demonstrate increased knowledge about child development.
- 80% of parents will demonstrate developmentally appropriate expectations.
- 90% of parents will have no confirmed case of abuse/neglect after enrollment into Parents as Teachers
- 90% of enrolled parents will self report improved access and utilization of services
- 90% of parents will report supportive relationships with others
- Additional evaluations will be conducted by the state, and our staff will participate as needed.
- For families served by **CaCoon:**
 - Evaluations will be conducted by the state, and our staff will participate as needed.
- For families served by **Healthy Start:**
 - Evaluations will be conducted by the state and local Commission on Children and Families. Staff will participate as needed.

Decrease Prenatal Tobacco Use Action Plan 2009/2010

Current Condition or Problem:

Smoking during pregnancy is a problem for the fetus, because nicotine passes the placental barrier and the carbon monoxide in tobacco smoke combines with hemoglobin to reduce the oxygen-carrying capacity of the blood. These factors contribute to complications such as slower fetal growth, low birth-weight, an increased risk of miscarriage, premature labor, an increased risk of stillbirth and pre-term delivery. These babies also have a greater risk of developing health problems within a few months after birth, such as asthma, allergies, ear infections, sudden infant death syndrome (SIDS), and lifelong disabilities. In addition, there is a possible link between smoking by a mother and attention deficit disorder (hyperactivity) in children.

Update: According to the 2007 statistics, 21.7% of pregnant women in Coos County used tobacco, reflecting a significant decrease from the previous year (26.3%) yet still nearly twice that of the state rate of 11.7%. Coos County is now ranked 5th highest in the state for pregnant women who smoke.

Of the women enrolled in our Healthy Beginnings (MCM) program in 2007-2008, 48% used tobacco products during their pregnancies. While we may have had a disproportionate number of smoking women enrolled in our prenatal program compared to the county, 41% of these women were successful in their efforts to quit and 12% were able to decrease their level of smoking. (Note: Healthy Beginnings (MCM) program was discontinued in 2008/09 due to the inadequate payments from Medicaid.)

Goals:

- Continue to offer 5As cessation trainings to health care providers, as well as other tobacco and pregnancy outcome related trainings.
- Promote the use of the Oregon Tobacco Quitline by Coos County residents and smoking cessation resources (such as Fresh Start Family and classes by DOCS)

Activities:

- Continue to use the 5As of cessation protocol in home visiting programs, WIC, and during family planning visits for women of childbearing age.
- Continue to offer/provide 5As cessation and motivational counseling trainings to various community partners. If funding is available, bring in speaker to provide local training for health care providers focusing on the 5 A's, motivational counseling, and stages of change.
- Continue to participate in the Chronic Disease Coalition and work with community partners to increase awareness and knowledge of the dangers / consequences of tobacco use during pregnancy.

- Continue to promote established cessation programs to case management providers, and healthcare personnel.
- Continue to refer to the Oregon Tobacco Quit Line and local cessation programs.
- Collaborate with Tobacco Prevention Program's Public Health Educator in tobacco related projects for pregnant women

Evaluation:

- WIC, Family Planning, and other home visiting programs will track the smoking status of their clients
- The 2008 Oregon DHS Center for Vital Statistics database will show a decrease in the number of pregnant women in Coos County who use tobacco

Family Planning
Reduce the Risk of Unintended Teen Pregnancy &
Assure High Quality Family Planning Services
Action Plan 2009/2010

Current Condition or Problem:

In 2007, there were an estimated 2,824 *women in need* (WIN), ages 13-44, according to Region X data. Our family planning clinic served 1,457 unduplicated or 50.8% of the WIN, compared to 1,647 clients served in 2006. According to the Healthy Teens Survey, 57.3% of the 15-17 year old females in the county are sexually active, and 25% of those were served by our agency in family planning. Of the total 476 teens served, 222 were in the age range of 10-17, and 254 in the age range of 18-19. Teen clients comprised 32% of the total clients that were served in the Family Planning Clinic, which is consistent with the previous year.

Update: Our teen pregnancy rates have decreased over the past few 5 years. Our rate for 2007 for females ages 15-17 achieved the Oregon benchmark of 20 per 1,000—it was 19.6, compared to the state's rate of 25.7. Our preliminary rate for 2008 shows further improvement at 13.9.

Funding to sustain our family planning services is becoming more challenging, with the loss of county general fund support and the eligibility requirement for citizenship in order to receive Medicaid payment through the family planning expansion project. The local Waterfall Clinic became an FPEP provider in 2006, and provides FPEP services to the same client pool that we serve. Teens are also served by Waterfall Clinic through the school based health center in Coos Bay, which receives public health funding.

Outreach activities have occurred on the local community college campus and at special community events for teens (Teen Summit and Teenopoly), and presentations in 2 school districts. Family planning clinic days at the Coquille satellite office are offered twice a month. The Students Today Aren't Ready for Sex (STARS) abstinence program was discontinued in 2007/08 due to lack of funds, and any outreach/education will be limited in FY 2008/09 due to the decrease in funding.

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

Problem Statement	Objective(s)	Planned Activities	Evaluation
Changes in FPEP enrollment have led to increased staff time without additional reimbursement, threatening the ability of the agency to maintain current level of service.	1) Increase revenue from donations by 10% for the period ending June 30, 2008	<ul style="list-style-type: none"> Develop a donation policy and procedure consistent with Title X guidelines. Train staff in positions to make the donation requests. Implement donation request policy. Evaluate policy for consistency, fairness and effectiveness 	<ul style="list-style-type: none"> Quarterly and fiscal year end revenue reports Customer feedback Staff feedback

Update: Objective was met in 2006/07. Four new sources of donations have been established, in addition to an increase in client donations. A customer satisfaction survey reveals positive comments from over 90% of the respondents. This objective will be continued for FY 09/10.

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 IUDs due to untrained staff.	1 NP will be able to offer IUD insertions by September 30, 2007	<ul style="list-style-type: none"> Identify IUD training events and resources. Paragard has been contacted and we expect a return call from the representative for our area. A local physician has been contacted and is willing to do some precepting. Support NP to attend an IUD training and preceptorship. Add IUD as a birth control option for clients 	<ul style="list-style-type: none"> IUD training certificate # of IUDs inserted/removed

Update: Objective was met in 2006/07. NP received IUD training and since the training has inserted 17 IUDs.

Goal 3: Assure ongoing access to continuing education on contraceptive methods.

Problem Statement	Objective(s)	Planned Activities	Evaluation
Continuing education on contraceptive methods is costly due to distance required to drive, and time out of clinic, with resulting loss of revenue.	Obtain FP education and CEUs without going out of town.	Register staff for phone and web conferences.	6 FP/Title X conferences will have been attended via phone conferencing.

Update: Objective was met in 2008/09. Staff attended the following Webinars:

- Sexual History – Taking: Focus on STIs
- Charting a Course Through Changing Tides: An Evidence Based Examination of Hormone Therapy in Women’s Health
- Contraceptive Management Coding Session I
- Contraceptive Management Coding Session II
- Contraceptive Management Coding Session III
- Contraceptive Management Coding Session IV

This objective will be continued for FY 09/10.

Evaluation of WIC Nutrition Education Plan FY 2009-2010

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 WIC Program's Key Nutrition Messages and identify which ones they need additional training on.

Outcome evaluation:

Response: How were the WIC Program's Key Nutrition Messages shared with staff in your agency? During the August staff meeting we reviewed the Oregon WIC Key Nutrition Messages. We discussed these messages and staff could not identify any as needing to have additional training.

Activity 2: By March 31, 2009, staff will review the proposed food package changes and:

- *Select at least three food package 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 change.*

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

- How did staff review the proposed food package changes?
- Which nutrition education messages were identified that need to be modified?
- How will these messages be shared with participants?

Response: The food package changes have been read and discussed. They are being shared with participants at their scheduled visits.

We are discussing if there any nutrition education messages that need to be modified. We have not identified any at this time.

Activity 3: Identify your agency training supervisor(s) and staff in-service dates and topics for FY 2008-2009.

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: The in-services were conducted as planned and the objectives were met. The May breastfeeding in-service will be held as planned.

These in-services addressed the following core areas of the CPA Competency Model:

To understand the WIC nutrition assessment process including risk assignment and documentation.

To know how to synthesize and analyze data to draw appropriate conclusions.

To provide appropriate targeted Nutrition Education for WIC participants using principles of participant centered education in both individual and group settings.

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 assessment steps from the Dietary Risk Module and identify which ones they need additional training on.

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

- Did staff review the assessment steps from the Dietary Risk Module?
- Which steps did staff identify as needing additional training on?
- How did this training occur?

Response: Staff attended the State sponsored training on the Dietary Risk Module. 3 weekly meetings were held to provide additional training.

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.

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

- How have staff modified their approach to individual counseling after completing the Nutrition Risk and Dietary Risk Modules?

Response: Staff are practicing critical thinking when choosing Nutritional and Dietary risks. We have used the tool of staff observation and lessons from Oregon WIC Listens.

Goal 3: Improve the health outcomes of WIC clients and WIC 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 objective and strategy to facilitate healthy behavior change for WIC staff.

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

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

Response: This health department has an on going goal of increasing the servings of fruits and vegetables at worksites, break rooms, meetings and events. Healthy alternatives are offered at staff occasions.

Activity 2: Identify your objective and strategy to facilitate healthy behavior change for WIC clients.

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

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

Response: Our choice was to decrease screen time. Pediatricians and other health professionals are receiving information on the limit of no screen time under 2 years of age and a limit of 2 hours after 2 years.

We participated in turn off TV week and posted a bulletin board promoting physical activity.

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

Year 2 Objective: During plan period, in order to help improve breastfeeding outcomes for WIC participants, 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 objective and strategy to improve breastfeeding outcomes for WIC clients.

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

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

Response: We participated in World Breastfeeding week. We have reactivated the local breastfeeding coalition and plan to meet quarterly or more often if desired.
Fast sheets are available for local business on the legislation on pumping breastmilk at work.

WIC Nutrition Education Plan Form
FY 2009 – 2010

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

Year 3 Objective: During planning period, staff will be able to work with participants to select the food package that is the most appropriate for their individual needs.

Activity 1: Staff will complete the appropriate sections of the new Food Package Assignment Module by December 31, 2009.

Resources: Food Package Assignment Module to be released summer 2009.

Implementation Plan and Timeline:

Staff will attend 2009 State meeting and workshops on new food packages. July inservice will be on the new packages.

Activity 2: Staff will receive training in the basics of interpreting infant feeding cues in order to better support participants with infant feeding, breastfeeding education and to provide anticipatory guidance when implementing the new WIC food packages by December 31, 2009.

Resources: Sessions on Infant Feeding Cues at the WIC Statewide Meeting June 22-23, 2009.

Implementation Plan and Timeline:

Staff will attend 2009 state meeting and sessions on infant feeding cues. These will be reviewed at the October 2009 inservice.

Activity 3: Each local agency will review and revise as necessary their nutrition education lesson plans and written education materials to assure consistency with the Key Nutrition Messages and changes with the new WIC food packages by August 1, 2009.

Example: Pregnant women will no longer be able to routinely purchase whole milk with their WIC FIs. If the nutrition education materials your agency uses indicates all pregnant women should drink whole milk, those materials would need to be revised.

Implementation Plan and Timeline:

Nutrition education plans will be reviewed by August 1, 2009 to assure consistency with the Key Nutrition Messages and changes with the new WIC food packages.

Activity 4: Identify your agency training supervisor(s) and projected staff in-service training dates and topics for FY 2009-2010. Complete and return Attachment A by May 1, 2009.

Implementation Plan and Timeline:

Identify topics and submit by May 1, 2009.

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

Year 3 Objective: During planning, each agency will develop a plan for incorporating participant centered services in their daily clinic activities.

Activity 1: Each agency will identify the core components of participant centered services that are being consistently utilized by staff and which components need further developing by October 31, 2009.

Examples: Use state provided resources such as the Counseling Observation Guide to identify participant centered skills staff are using on a regular basis. Use state provided resources such as self evaluation activities done during Oregon WIC Listens onsite visits to identify skills staff are working on and want to improve on.

Implementation Plan and Timeline:

During August, we will use state resources and self evaluation activities done during Oregon WIC Listens onsite visits to identify skills staff are working on and want to improve on

Activity 2: Each agency will implement at least two strategies to promote growth of staff's ability to continue to provide participant centered services by December 31, 2009.

Examples: Using the information from Goal 2, Activity 1, schedule quarterly staff meeting time to review Oregon WIC Listens Continuing Education activities related to participant centered skills staff identified they want to improve on. Schedule time for peer to peer observations to focus on enhancing participant centered services.

Implementation Plan and Timeline:

Quarterly staff meetings will provide time to review Counseling Observation Guides and self evaluation activities. Time will be scheduled for peer to peer observations to focus on enhancing participant centered services.

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

Year 3 Objective: During planning period, each agency will develop a plan to consistently promote the Key Nutrition Messages related to Fresh Choices thereby supporting the foundation for health and nutrition of all WIC families.

- *Breastfeeding is a gift of love.*
- *Focus on fruit.*
- *Vary your veggies.*
- *Make half your grains whole.*
- *Serve low-fat milk to adults and children over the age of 2.*

Activity 1: Each agency will implement strategies for promoting the positive changes with Fresh Choices with community partners by October 31, 2009.

Example: Determine which partners in your community are the highest priority to contact such as medical providers, food pantries, breastfeeding coalitions, and/or Head Start programs. Provide a staff in-service, written materials or presentation to those partners regarding Fresh Choices.

Implementation Plan and Timeline:

Head Start and Health Department partners will be offered a presentation on the WIC key nutrition messages.

Activity 2: Each agency will collaborate with the state WIC Research Analysts for Fresh Choices evaluation by April 30, 2010.

Example: Your agency is a cooperative partner in a state led evaluation of Fresh Choices such as hosting focus groups or administering questionnaires with participants.

Implementation Plan and Timeline:

We have participated in the Texas A&M Survey

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

Year 3 Objective: During planning period, each agency will develop a plan to promote breastfeeding exclusivity and duration thereby supporting the foundation for health and nutrition of all WIC families.

Activity 1: Using state provided resources, each agency will assess their breastfeeding promotion and support activities to identify strengths and weaknesses and identify possible strategies for improving their support for breastfeeding exclusivity and duration by December 31, 2009.

Resources: State provided Oregon WIC Breastfeeding Study data, the breastfeeding promotion assessment tool and technical assistance for using the tool. Technical assistance will be provided as needed from the agency's assigned nutrition consultant and/or the state breastfeeding coordinator.

Implementation Plan and Timeline:

We will use the state data to monitor our breastfeeding success and request assistance as needed from the state.

Activity 2: Each agency will implement at least one identified strategy from Goal 4, Activity 1 in their agency by April 30, 2010.

Implementation Plan and Timeline:

We will implement at least one identified strategy from Goal 4, Activity 1 by April 30, 2010

Attachment A
FY 2009-2010 WIC Nutrition Education Plan
WIC Staff Training Plan – 7/1/2009 through 6/30/2010

Agency: Coos

Training Supervisor(s) and Credentials: Phyllis Olson, BA, completed all Nutrition Education Modules

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, 2009 – June 30, 2010. State provided in-services, trainings and meetings can be included as appropriate.

Quarter	Month	In-Service Topic	In-Service Objective
1	July, 2009	Food Package Assignment Module (State Meeting)	Work with participants to select food package most appropriate for their needs
2	October, 2009	Infant Feeding Cues (State Meeting)	Support participant with infant feeding and breastfeeding information and provide anticipatory guidance.
3	January,2010	Review Nutrition Education lesson plans and update	Promote staff ability to provide participant centered services focusing on Key Nutrition Messages
4	April, 2010	Strategies for improving support for BF exclusivity and duration	Increase breastfeeding exclusivity and duration.

Health Statistics Action Plan 2009/2010

Current Condition or Problem:

As one of the services required by Oregon law, our department registers all births and deaths in the county. We also review the health statistics which have been compiled by the state related to program areas that we provide. In some of our programs, we have not had a systematic approach to collecting health data or outcome measures that have not otherwise been required by the funding source.

Goal:

Continued improvement in departmental statistics gathering on health indicators or outcome objectives.

Activities:

- Each program supervisor will review tools and methods for collecting outcome data related to targeted program objectives.
- Where there are gaps in data collection, supervisors will develop tools or processes for measuring program effectiveness.

Evaluation:

Achievement of improved data collection in program areas.

Health Information and Referral Services Action Plan 2009/2010

Current Condition or Problem:

Public Health clients often have needs that are out of the range of services offered within our department. Some are aware of the information or services they are seeking, and call asking for contacts and phone numbers. Many, however, are unaware of services available, and therefore do not inquire. These clients are dependent on Coos County Public Health staff to take the initiative and suggest services and opportunities that might be beneficial to them.

All Department programs are currently involved in providing information and making referrals to clients for services offered at the Health Department, as well as services of other agencies. The following are examples of common information and referrals provided by our department. The Family Planning Clinic provides options counseling to clients who become pregnant, and refers the client to the appropriate agency. The Oregon Health Plan / Oregon Mothers Care outreach specialist assists clients in applying for publicly funded health insurances, and in locating affordable primary healthcare services. WIC ensures that client's vaccinations are current by referring to the Coos County Public Health Immunization Clinic when scheduled immunizations are due. Home visiting nurses regularly refer parents of young children and pregnant women to free stop smoking classes offered by the local hospital.

Goals:

Coos County Public Health has the goal to assure those who qualify become connected with the many services available through public and private agencies designed to improve their quality of life. We plan to improve our already extensive referral program to provide even better, more prompt and complete information to members of our community. We want to see information of importance to the community passed on in the most effective way, to keep them informed and prepared in the case of an emergency, such as an outbreak of a communicable disease, a natural disaster or terrorist attack.

Activities:

To enable our staff to continue to improve their abilities to successfully refer our clients to other agencies for appropriate services:

- We will continue to invite individuals from other agencies, such as Red Cross and Child Welfare Services, to make presentations at our monthly all-staff meetings, so that our staff will become familiar with services provided by other agencies.
- We will participate in agency health fairs.
- New employee orientation will include an emphasis on the importance of our information and referral service, to ensure that new staff coming in will catch the vision of holistically meeting the needs of the community through interagency cooperation.

To facilitate the public's need to access accurate and pertinent information in a prompt manner:

- We will continue to strive to enhance our website to include more links to state and federal agencies, such as the CDC.
- We will continue to include our website address in all public information campaigns we make in other media, such as newspaper, radio or television.
- We will post health information and our department's services on our electronic sign.
- We will publish an annual report describing our services.

Evaluation:

We will track who has attended the agency presentations made at our staff meetings. We will review orientation checklists to see that the proper emphasis on information and referral services has actually been included in all incoming staff orientations.

We will monitor our website with regularly scheduled inspections to track the condition and progress being made, checking for completeness and currency of the information. We will make needed adjustments or training to enable staff in our respective programs to update information relevant to their program. We will review all advertising to insure the website address is included.

Licensed Facilities (& Other Institutions)

Action Plan 2009/2010

Current Condition:

Update: Safety and prevention of illness are the goals of the Environmental Health Program for the **238** licensed temporary restaurants, **420** annually licensed facilities and **55** other inspected institutions operating within Coos County in 2008. Restaurants, public pools, bed and breakfasts, RV parks, overnight lodging, organization camps, schools, and child care centers, are inspected and have education and consultation services available.

The Environmental Health Program benefits virtually every person residing in or traveling through Coos County. Consider in the charts below the numbers of meals served, nights stayed by RV campers, and nights stayed in hotel/motels within Coos County at licensed facilities:

12,297 Seats in licensed restaurants exist in Coos County.

If all of these seats are filled only 3 times a week that means:

1,933,932 meals were served by Food Service establishments licensed and regulated by the Coos County Environmental Health Office.

1,185 Sites licensed for overnight RV camping exist in Coos County.

If all of these sites were occupied only 3 nights a week that means

184,860 Nights of camping accommodation were provided by RV parks licensed and regulated by the Coos County Environmental Health Office.

1,101 Rooms licensed for Overnight Lodging exist in Coos County.

If all of these rooms were occupied solo for only 3 nights a week that means

171,756 Nights lodging were provided by Traveler's Accommodations licensed and inspected by the Coos County Environmental Health Office.

Added together, on approximately 2.3 million occasions, consumers in Coos County benefited from Environmental Health services. The fact that in 2008, Coos County Public Health documented only 18 consumer complaints regarding all licensed establishments in Coos County, lends credibility to the idea of maintaining a proactive Environmental Health Services approach.

Goals

Environmental Health Services provide education, consultation and inspection services to assure:

- Community visitors have clean and safe traveler's accommodations
- Public pools and spas are free of disease causing germs
- Food workers know how to keep food safe
- Restaurants, schools and day care facilities serve safe food
- Day care facilities are free of environmental injury risks.

Activities

- License and inspect food service facilities as required by OAR 333 Division 12. Inspection frequency may increase based on epidemiological risks.
- Provide Food Manager Certification Training
- Provide Food Handler Training at least monthly
- Provide Food Handler Training outreach in Bandon, Myrtle Point, and Coquille
- Follow-up on all allegations of food borne illness
- Initiate communicable disease epidemiological investigations of confirmed food borne illness outbreaks together with communicable disease nurses immediately upon notification
- License and inspect temporary food vendors
- License & inspect tourist accommodations for health and safety risks as required by OAR 333 Division 12
- License and inspect public pools for health and safety risks as required by OAR 333 Division 12
- Investigate complaints regarding legitimate environmental concerns at public pools relating to public safety and health
- Investigate complaints regarding legitimate environmental concerns relating to public safety and health at tourist accommodations

Evaluation

Update: The *Licensed Facility Statistics Report* provides a statistical evaluation for work done over the year. Prominent points from 2008 include:

License Type	Percentage of Required Inspections Completed	Closures	Misc. Consumer Complaints
Public Pool	100%	0	0
Lodging	100%	0	2
RV Camp	100%	0	1
Food Service	99%	0	15

Food Complaints	15
Confirmed Cases of Food Borne Illness	15
Food Handler Training Cards Issued	659
Food Service Mangers Certified	61

Safe Drinking Water Action Plan 2009/2010

Current Condition

Everyone takes for granted the quality of Oregon’s drinking water. But nationally, several water borne disease outbreaks have provided a reminder that if people drink contaminated water, they can get sick and even die. A keen interest in protecting drinking water has been renewed by the recognition that public water systems provide an easy conduit for a terrorist’s threat into many homes. Our services provided in the Drinking Water Program are intended to assure good quality water.

Update: Approximately 50,000 Coos County residents live where they are served by 82 known water systems. Most of the remaining 12,000 county residents (20%) live where they rely on private water supplies. Among the 82 recognized water systems in Coos County, 53 are designated by EPA as public water systems. Oregon Revised Statutes expand the definition of public water system to include regulation for another 29 smaller water systems.

County services provided for public water systems are covered in the Drinking Water Systems Assurances as per delegation agreement between Coos County Public Health and the State Drinking Water Program. This means the Environmental Health Program has direct responsibility to work with approximately 85% of the county’s public water systems. The remnant of service is the responsibility of either the State Drinking Water Program office or the Oregon Department of Agriculture.

Our services in this program are primarily directed toward helping public water system operators sort through the maze of rules which help to assure the quality of the drinking water. Water systems operators are required to take steps to physically protect the water and regularly sample for potential contaminants. Dozens of potential contaminants may need to be sampled, but the following table notes some important contaminants of concern.

Contaminate	Examples		Implications
Chemical	Nitrates		Blue Baby Syndrome
	Trichloroethylene		Solvent linked to cancer, birth defects, reproductive problems
	Lead		Effects central nervous system and child development
Microbial	Bacteria	Escherichia coli O157:H7	Acute bloody diarrhea, abdominal cramps - occasionally leads to kidney failure
	Viruses	Hepatitis A	Fever, abdominal pain, fatigue, jaundice, loss of appetite, intermittent nausea, dark urine
	Parasites	Cryptosporidium	Symptoms include diarrhea, abdominal cramps, nausea, occasionally vomiting, low-grade fever

The potential for health problems from drinking water is illustrated by localized outbreaks of water borne disease. For example, in Oregon in 1993 and 1994, there were 30 renowned disease outbreaks associated with drinking water - 23 were associated with public water systems and 7 with private systems.

Goals:

Assure the availability of safe drinking water, meaning water which is sufficiently free from biological, chemical, radiological, or physical impurities such that individuals will not be exposed to disease or harmful physiological effects.

EPA Designated Public Water Systems: Increase to at least 95% the percentage of people who receive a supply of drinking water from public water systems that meet all EPA health based safe drinking water standards.

Non-EPA Public Water Systems: Seek to provide public outreach to operators of water systems including applicable health based standards for operation.

Public Water Systems:

Consult with system operator on steps to correct any water quality violations

Work with system operators with water quality noncompliance and sampling issues

Physically survey each water system no less often than every 5 years

Identify previously unrecognized [Non-EPA] public water systems and their operators

Non-Regulated/Private Water Systems:

Refer users of private water to education sources such as OSU Extension

Consult with suspected victims of water borne illness regarding ensuring drinking water safety as they are referred by Communicable Disease investigation staff

Evaluations:

Update: The following data tables represent work done in 2008 to ensure safe drinking water.

EPA Water Systems

Measure	Value
Number of consultations for water quality violations	13
Number of contacts to assist in correcting chronic noncompliance	1
Number of water system sanitary surveys conducted	13
Percentage of "EPA regulated" public water systems in compliance with water quality standards	98%
Public Water Systems added (or reactivated) to the State's inventory	1

Drinking Water Systems Not Regulated by EPA

Measure	Value
Number of referrals	1
Investigations into suspected water borne illness complaints	8
Number of water borne disease outbreaks - confirmed	0

Action Plans

For

Other Public Health Concerns

HIV Client Services

Action Plan 2006/07

This action plan has been deleted for 2008/09 and 2009/10 because Coos County Public Health no longer offers this program. The State contracts with HIV Alliance in Eugene to provide this service in Coos County.

Public Health Emergency Preparedness

Action Plan 2009/10

Current Condition:

Coos County Public Health (CCPH) continues to work towards coordination of emergency planning with our partners within the county, within Region 3 (Coos, Curry, Douglas, and Lane Counties), and the state. The Public Health Administrator continues to chair the local Health Emergency Response Team (HERT) that has met monthly since October 2001 for emergency response planning. The Administrator also participates on the Regional Preparedness Advisory Board, which coordinates the HRSA preparedness activities with hospitals and providers in Region 3, and with the Public Health Preparedness Leadership Team, which makes recommendations for the state's public health preparedness program. Due to staff attrition in 2007, a new Public Health Preparedness Coordinator (PHP) was hired at the end of December.

Response Capability: Update: We have had a 29% reduction in staff since FY 06/07—including 6 nurse positions—which will decrease this department's ability to respond to an outbreak/incident of significant size. This staff reduction also has decreased the number of individuals available to be on-call 24/7 for reporting purposes.

We continue to have designated staff for on-call response to 24/7. However, we now have reports relayed to us after hours through the Sheriff's dispatch center, as we have discontinued the use of a 24/7 pager for disease reporting.

Goals:

- To be prepared to respond to reports of unusual events, either man-made or naturally occurring, in an efficient and organized manner.
- To provide education to the community on how they can best protect themselves from both known and emerging diseases or from an act of willful destruction to health or property, such as use of a weapon of mass destruction (WMD) or an act of bioterrorism (BT).
- To continue to participate in the ongoing revision of our County Emergency Operations Planning to ensure that Public Health is prepared to respond to incidents in a coordinated manner with our county government, and with our community and state partners.

- To continue to improve communications between local emergency 1st responder agencies, local healthcare agencies, regional partners, and state partners to effectively respond to an emergency event while keeping the public safe and informed with up-to-date information
- To continue to develop relationships with businesses, schools, faith-based organizations, tribal agencies, social service agencies, and other community members to facilitate community-wide public health emergency preparedness and response.

Activities for 09-10:

- Continue to provide 24/7 response to the health care system for reportable diseases
- Update procedures for CD investigation , quarantine, isolation, and restriction of movement, and procedures for surge capacity of paid and volunteer staff during a public health emergency event.
- Update the county website with pertinent information on communicable diseases and/or public health preparedness topics.
- Continue to facilitate the local Health Emergency Response Team meetings, monthly.
- Provide continuing education to the Public Health staff on potential duties and/or responsibilities during a communicable disease outbreak, pandemic illness, and/or natural disaster health recovery.
- Encourage participation by our local tribal officials, schools, faith-based organizations and social service agencies in planning for incidents regarding communicable disease and/or other public health emergencies.
- Continue to test current communication capabilities, including alternate communication devices, with all local partners to ensure ability to distribute information during emergency situations.
- Complete the incidence command training for all staff, based on their response roles, according to the National Incidence Management System requirements.
- Complete staff training in the use of the Health Alert Network system, and test the local use of the system.
- Participate in local/regional exercises with community partners.
- Complete and update the necessary public health emergency response and health recovery plans, annexes and attachments, with a focus on chemical and radiation.
- Continue to work with law enforcement, hospitals, health care agencies, emergency management, local businesses, other government agencies, and other client-services based agencies to address needs of vulnerable populations during an emergency event.
- Work with local businesses and schools to facilitate the preparation of emergency response health plans, with an emphasis on pandemic flu response.
- Work with emergency response agencies on development and review of current emergency response plans and procedures for the proposed Liquid Natural Gas facility terminal.

- Continue to participate in all monthly LHD Public Health Preparedness conference calls, as required.

Evaluation

Evaluation of our progress will be done semi-annually and by participation in the Annual . Review with other preparedness coordinators in Region 3.

Challenges

The contractual expectations in this program are challenging and exceed what is funded.

Unmet Needs for Coos County 2009/10

The funding received from the state or federal government is strictly limited to specific programs. The expectations which come with those funds are based on standards which are to protect and promote public health, but are often unrealistic for the dollar amounts given, especially when there are no local funds contributing to public health personnel or program supplies. Coos County Public Health lacks discretionary dollars from either state or county sources to address public health needs specific to our county, unless we are able to obtain special grants from foundations, service clubs, or individuals. When budget cuts resulted in the loss of our department's prevention manager position in 2006, and one of our two nurse managers in 2008, then any grant writing that was to be done had to be added to the already full workloads of the remaining supervisors. Competing priorities to manage current programs have resulted in very little time to seek additional revenue. Stable funding to maintain a grant writing position could bring in additional dollars to enhance programs and services. However, the expectation that mandated public health programs can be maintained on "soft" grant money is unrealistic. Unlike a business that can charge the true cost for a product or service, public health programs that are mandated to serve everyone, regardless of ability to pay, or that do not have a billable component, require a stable source of government funding. This Department could also benefit by having additional personnel to participate in community health forums and assessment projects, an essential function of public health which is becoming increasingly more difficult to do because of reductions in staffing.

Our environmental health specialists are funded only to administer the licensed facilities program and the drinking water program, plus some inspections of schools and daycare facilities, which are done for a fee. An additional source of funding would enable these environmental health experts to assist the community with issues such as nuisance complaints, problems with mold, blue-green algae, and climate change. These activities were done in the past, when the Health Department received County general fund contributions for the environmental health program.

Persons who are seeking exams for diagnosis of sexually transmitted diseases (STDs) at the Health Department and who lack funds to pay for the exams have been grateful for the generosity of the Coquille Tribal Community Grant, which has provided \$5,000 for vouchers to pay for exams, for the second year in a row. Our cases of sexually transmitted disease are consistently high, and we have had no source of funding (federal, state, or local) to do any outreach for prevention. In the first two months of 2009, we had more cases of gonorrhea than we usually have in a year. Funding is needed to help us aggressively attack this problem in our community. We are slated to receive some HIV prevention funds this next year, but at the time of this writing, this prevention funding from the state is tenuous because it is on the cut list to balance the state budget. Medications and lab tests for communicable diseases are also on the cut list.

Interventions by public health nurses with new mothers before and after they give birth are a cost effective way to help babies get a better start in life, especially for families who are at risk due to health problems, poverty (inability to pay rent and utilities), poor nutrition, drug use, domestic violence, mental health problems, disabilities, and generational lack of parenting knowledge.

We currently have a significantly reduced capacity to address these perinatal needs in our county. We had to eliminate 2 home visiting nurse positions, and discontinue our maternity case management home visits, due to the inadequate reimbursement rate paid by Medicaid for this service (and the lack of other funding). The potential loss of the Babies First! nurse home visitation program, which is on the state cut list, could wipe out our home visiting programs, including CaCoon, which serves medically fragile children. Healthy Start, which serves first birth families, is also slated for budget reductions that would cut in half the number of families served.

The expectation by the federal government for comprehensive family planning services under the federal Title X program exceeds what can be accomplished with the federal grant award. This mismatch between funding and program requirements will result in fewer women being served in Coos County, at a time when many women are increasingly unable to afford contraceptive services, due to loss of their jobs and health insurance. Without a significant increase in revenue from some source, a quota for Title X clients will have to be enforced. This is counter to the goal of this program, which is to assure access to all low income women in need of contraceptive services.

Data about our community's needs and the services that we provide help us to evaluate our effectiveness and guide us in our efforts. We are expected to enter information into multiple state data bases, which can be labor intensive. However, we find that we are unable to extract the local information that we need from some state data bases, (e.g., ORCHIDS and EBRIS) and also spend many hours to correct errors resulting from poor system design in the MMIS Medicaid billing system. We also lack a good business/accounting software that will interface with our County's accounting system. Funds to purchase a better accounting system would improve efficiency for our business processes and mandated record keeping.

And finally, the lack of medical and dental care for many who live here continues to be a problem that is mirrored at the state and national level. While our state and federal governments seek a solution that will provide health insurance for more people, we are hopeful that public health prevention efforts will be included in the solution, so that we can have a greater impact on the high rate of tobacco related and other chronic diseases in Coos County.

Budget Statement

Contact to receive a copy of our approved budget document:

Sherrill Lorenzo

Business Operations Manager

Coos County Public Health

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Comprehensive Plan Statement

Senate Bill 555

The Coos County Board of Commissioners, who are the Local Public Health Authority, also oversee the Coos County Commission on Children and Families, which was responsible for coordinating the comprehensive planning process in Coos County.

Health Department staff have participated in the most recent update to the comprehensive plan. Annual plan topics which are also included in the comprehensive plan include: prenatal care, immunizations, child abuse, use of alcohol, tobacco and other drugs, and teen pregnancy.

Description of The Coos County Local Board of Health

The Local Board of Health is comprised of the Coos County Board of Commissioners (BOC). The Public Health Administrator reports directly to the BOC. The BOC holds weekly meetings, and any business or operational needs for the Health Department can be placed on the BOC's agenda. The Public Health Administrator meets frequently with the BOC, at least once a month or more often. There is no Public Health Advisory Board.

VII. Minimum Standards Coos County Public Health

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

Organization

1. Yes No A Local Health Authority exists which has accepted the legal responsibilities for public health as defined by Oregon Law.
2. Yes No The Local Health Authority meets at least annually to address public health concerns.
3. Yes No A current organizational chart exists that defines the authority, structure and function of the local health department; and is reviewed at least annually.
4. Yes No Current local health department policies and procedures exist which are reviewed at least annually.
5. Yes No Ongoing community assessment is performed to analyze and evaluate community data.
6. Yes No Written plans are developed with problem statements, objectives, activities, projected services, and evaluation criteria.
7. Yes No Local health officials develop and manage an annual operating budget.
8. Yes No Generally accepted public accounting practices are used for managing funds.
9. Yes No All revenues generated from public health services are allocated to public health programs.
10. Yes No Written personnel policies and procedures are in compliance with federal and state laws and regulations.
11. Yes No Personnel policies and procedures are available for all employees.
12. Yes No All positions have written job descriptions, including minimum qualifications.
13. Yes No Written performance evaluations are done annually (or according to County policy)..
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. (There is not a single manual for all forms.)
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. (Only as needed.)
31. Yes No ___ Staff is knowledgeable of and has participated in the development of the county's emergency plan.
32. Yes No ___ Written policies and procedures exist to guide staff in responding to an emergency.
33. Yes No ___ Staff participate periodically in emergency preparedness exercises and upgrade response plans accordingly.
34. Yes No ___ Written policies and procedures exist to guide staff and volunteers in maintaining appropriate confidentiality standards.
35. Yes No ___ Confidentiality training is included in new employee orientation. Staff includes: employees, both permanent and temporary, volunteers, translators, and any other party in contact with clients, services or information. Staff sign confidentiality statements when hired and at least annually thereafter.
36. Yes No ___ A Client Grievance Procedure is in place with resultant staff training and input to assure that there is a mechanism to address client and staff concerns.

Control of Communicable Diseases

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

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

Environmental Health

47. Yes No Food service facilities are licensed and inspected as required by Chapter 333 Division 12, 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. (DEQ)

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. **(by DEQ)**
64. Yes No The health and safety of the public is being protected through hazardous incidence investigation and response. **(by DEQ)**
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. (other agencies contribute to regulation)
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. (Added per G.S. request, not in program indicators)

Health Education and Health Promotion

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

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

Nutrition

73. Yes No Local health department reviews population data to promote appropriate nutritional services.

74. The following health department programs include an assessment of nutritional status:

- a. Yes No WIC
- b. Yes No Family Planning
- c. Yes No Parent and Child Health
- d. Yes No Older Adult Health
- e. Yes No Corrections Health (n/a)

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

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

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

Older Adult Health

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

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

80. Yes No Health department maintains a current list of resources and refers for medical care, mental health, transportation, nutritional services, financial services, rehabilitation services, social services, and substance abuse services.

81. Yes No Prevention-oriented services exist for self health care, stress management, nutrition, exercise, medication use, maintaining activities of daily living, injury prevention and safety education. (Funds are lacking for some of these topics.)

Parent and Child Health

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

83. Yes No Immunizations are provided for infants, children, adolescents and adults either directly or by referral.
84. Yes No Comprehensive family planning services are provided directly or by referral.
85. Yes No Services for the early detection and follow up of abnormal growth, development and other health problems of infants and children are provided directly or by referral.
86. Yes No Child abuse prevention and treatment services are provided directly or by referral.
87. Yes No There is a system or mechanism in place to assure participation in multi-disciplinary teams addressing abuse and domestic violence.
88. Yes No There is a system in place for identifying and following up on high risk infants.
89. Yes No There is a system in place to follow up on all reported SIDS deaths.
90. Yes No Preventive oral health services are provided directly or by referral.
91. Yes No Use of fluoride is promoted, either through water fluoridation or use of fluoride mouth rinse or tablets.
92. Yes No Injury prevention services are provided within the community.

Primary Health Care

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

Cultural Competency

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

Health Department Personnel Qualifications

Local health department Health Administrator minimum qualifications:

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

Answer the following questions:

Administrator name: Frances Smith

- Does the Administrator have a Bachelor degree? Yes No
- Does the Administrator have at least 3 years experience in public health or a related field? Yes No
- Has the Administrator taken a graduate level course in biostatistics? Yes No
- Has the Administrator taken a graduate level course in epidemiology? Yes No
- Has the Administrator taken a graduate level course in environmental health? Yes No
- Has the Administrator taken a graduate level course in health services administration? Yes No

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

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

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

The Administrator will research options for a course in Biostatistics, and will plan to complete the course by 2011.

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

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

AND

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

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

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

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

OR

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

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

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

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

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

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

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

Nikki Whitty
Local Public Health Authority

Coos County
County

4/29/09
Date

Coos County Public Health

Organizational Chart

Proposed 2009-2010

