Promoting Community Health

KLAMATH COUNTY department of PUBLIC HEALTH

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Local Public Health Authority

Annual Plan

For FY 2010 – 2011

Klamath County, Oregon

Healthy People in a Healthy Community

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Public Health Services are for everyone and benefit the health of the whole community.

OUR MISSION: *Working together to promote healthy choices that improve the quality of life and well-being of our communities.*

I. EXECUTIVE SUMMARY AND FORWARD

A. **The Klamath County Public Health Authority provides the five essential services** mandated by Oregon State statute primarily through federal grant dollars passed through by the Oregon Public Health Services Division, and client and licensee fees. In addition we receive less than $1.00 dollar per capita from the State of Oregon. In 2007-08 we received general fund dollars from Klamath County taxes, for the first time. In 2008-09, we received an increase from Klamath County's share of General Alcohol and Tobacco taxes amounting to approximately $2.95 per capita. Our state awarded funding in 2009-2010 received a welcome transfusion of federal funding adequate to support our public health responsibilities for activating and H1N1 control and vaccination campaign. Additional funding should be provided in the future to support the incident command team system we found necessary to manage this incident

B. **Our communicable disease control and surveillance program** routinely handles on average 156 positive reports annually. Two thirds of these infections are sexually transmitted, and the overwhelming majority of these are Chlamydia cases. More troubling is the recent trend in Hepatitis C. Our numbers of acute Hepatitis C cases have increased and we continue to receive a steady flow of chronic Hepatitis C reports. Vaccine preventable diseases average about thirteen per year, but even small outbreaks of meningococcal disease and Pertussis can overwhelm our resources.

C. Parent and Child Health Services constitute the majority of our public health efforts. Klamath County continues to experience poor maternal child health indicators. In 2007, 25% of all children in Klamath County were living in households with incomes under 100% of the Federal Poverty level.

1. Given the lack of adequate funding to support comprehensive public health interventions for families at risk, we have focused these past years on innovations to leverage more funding for critically needed services, especially through targeted case management. One of these initiatives has been to maintain the nationally recognized best practices we pioneered with our campaign to eliminate early childhood cavities. We have marketed our successful strategies to four other Oregon counties with elevated rates of children under 100% of the Federal Poverty guidelines, with funding from the Northwest/Alaska Center to Reduce Oral Health Disparities. Our WIC program continues to be the flagship program for our Health Department services, now providing services to over 2700 clients annually. Program growth was made possible by the provision of additional WIC grants funds.

2. In 2009-10, our Family Planning Service levels saw a slight decrease due to H1N1 response efforts. Rates remained the same as in 2008-09 and 2007-08, in spite of the destabilizing changes in the family planning program which resulted from the new documented eligibility requirements of FPEP. The implementation of these new requirements has created the demand for almost one additional support staff person.

3. **Immunizations**
   Klamath County's most recent childhood immunization rates, from 2008, was 76.9%, a decrease from 80.5% in 2007. Figures for 2009 are not yet available.

D. **Environmental Health activities** are primarily focused on the Food Borne Illness Prevention program and Drinking Water System surveillance through contracts with the Oregon Public Health Services Division.

1. Approximately 365 facilities are licensed and inspected on an annual, semiannual or biannual basis.
2. The Environmental Health Division also inspects facilities that are licensed by other agencies. These include the school cafeterias, day care facilities, group homes, institutions and the summer lunch programs.
3. Over 170 Public Drinking water systems are monitored and surveyed. These systems range from small systems, serving 10 people, to systems serving over 500 people.
4. Our Environmental Health Services Division also has the critical responsibility of monitoring and controlling airborne particulate matter to ensure compliance with EPA air quality standards. We continue the process of implementing a new Air Quality Ordinance with much stricter regulations in order to meet the new federal airborne particulate matter standards.

E. Health Statistics

In 2006-07 the Department was required to initiate the new electronic Death Certificate program funded by Homeland Security. Although this technology has streamlined our issuance procedures, documentation and reporting, we experienced significant difficulties and increased time related to issuance because all the features of the new electronic reporting system are not operable currently. We are experiencing the need to enter data into our former data gathering system as well as the new electronic database. This double data entry results in a triple increase in the time needed to complete a death certificate transaction, a significant increase in workload to issue the 3,000 death certificates we process annually.

F. Health Information and Referral Services

Our licensed and registered providers are recognized for the excellent health information and education we extend by phone, in classes and in person on a myriad of public health topics, as well as on our services. We enjoy a good rapport with the local media, and routinely utilize both radio and television media to get public health messages to the public. Additionally, the Klamath County Health Department participates in providing information to the public via radio by participating in radio call-in features, answering questions pertinent to public health.

G. Emergency Preparedness

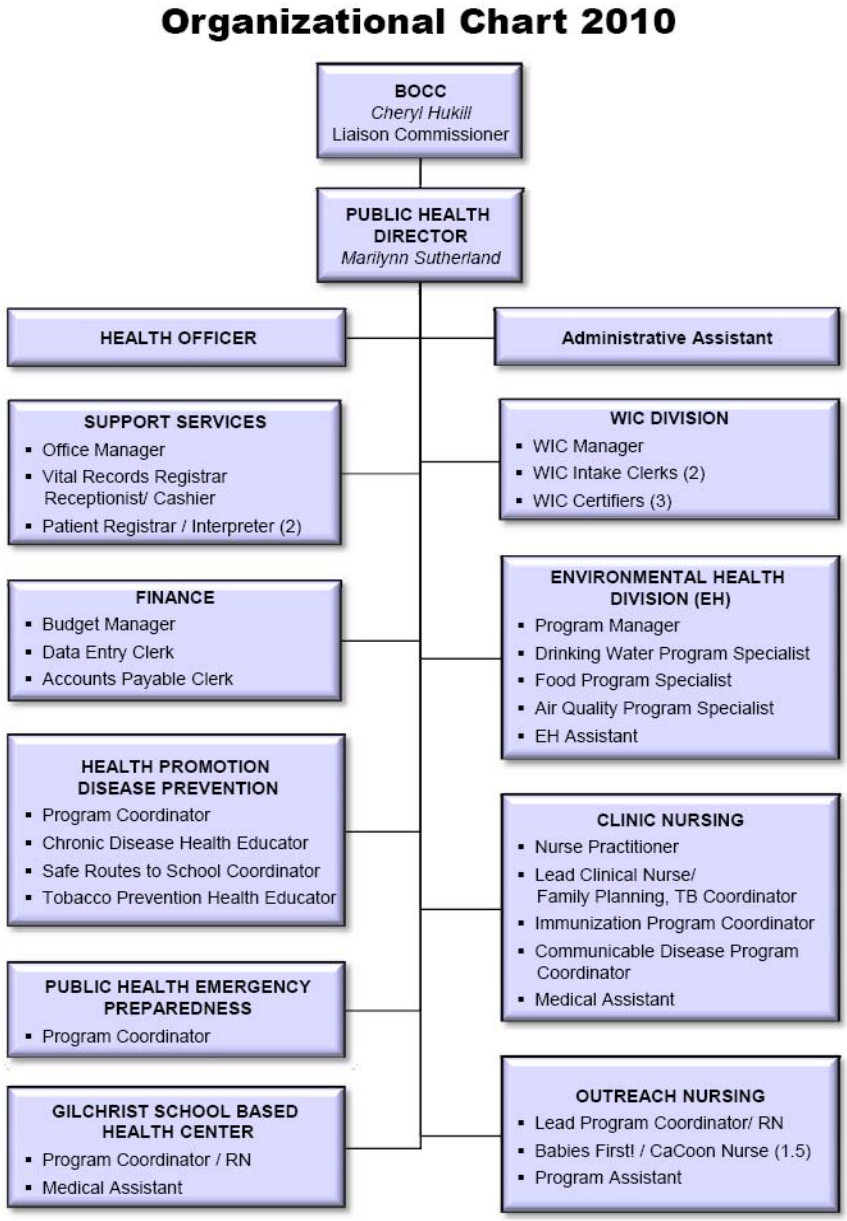
Increased electronic reporting and communication capacity continue to improve our public health preparedness. In 2009-2010, we developed a Contagious Disease Plan, continue the staging of exercises with our local military base and have increased surveillance efforts with Sky Lakes Medical Center. In support of Klamath County's Emergency Services Department, the Health Department has also been a key player in the development of a County wide interagency emergency

management team. We have a bilingual PHN to improve our capacity to better meet the need of special populations in an emergency. In addition, two of our medical records staff are bilingual and can serve as back-up if needed. Our public health preparedness team continues recommended ICS training.

Other

Broad community or true population based interventions have been limited by funding opportunities to My Future My Choice, TPEP, Healthy Communities and Public Health Preparedness programs. This year, the Klamath County Health Department received funding to implement a Safe Routes to School Program at two (2) elementary schools. The Klamath County Health Department continues to be the lead agency for the Healthy Active Klamath Coalition, collaborating with the community to improve the physical activity and nutritional status of school aged youth.

H. ORGANIZATIONAL CHART



I. INTRODUCTION TO KLAMATH COUNTY

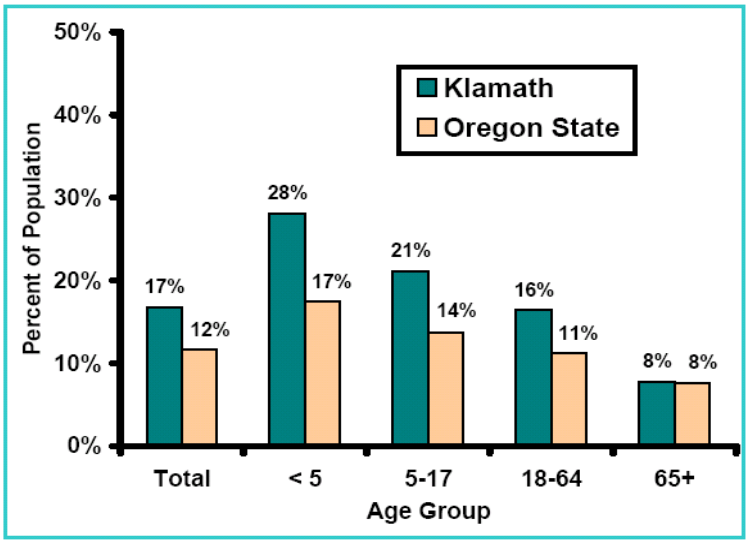
1. Klamath County sits at 4200 feet in a basin in south-central Oregon, bordered by the Cascade Mountains on the west.Klamath County is ranked the fourth largest Oregon County at 6135 square miles.
2. According to the U.S. Census, Klamath County had a population of approximately 66,247 residents in 2009, with a growth rate of 3.9% since April, 2000.

2009 Demographic Data	
AGE	
Under 18	23.1%
18 -64	60.5%
65 or older	16.4%
SEX	
Male	49.9%
Female	50.1%

ETHNICITY	
White	90.4%
Black	00.9%
Hispanic	09.9%
Asian	01.0%
American Indian	04.5%
2 or more races	3.0%

3. Economic Indicators:
   a) The 2007 OREGON BENCHMARKS reported an improving trend in Klamath County's economic well-being, from a rank of the 27th poorest in 2005 to a rank of 22nd among Oregon's 36 counties in 2007. But, for those over 65, every other age group in Klamath County has significantly higher poverty rates than the state average for each of those groups. More than 50% of all births are funded by Medicaid and 51% of all children attending school in Klamath County participate in the school lunch program.

Population By Age Under 100% of Federal Poverty Level in Oregon State and Klamath County, 1999



Data Source: 2000 U.S. Census.

b) More Klamath County youth graduate from high school than the state average, but a significant number of Klamath County's young people,(age 18-14) leave the County for educational and employment opportunities. Klamath County's current college completion rate of 15.9% is higher than the average for rural counties in Oregon, but significantly lower than the statewide three year average of 25.1%.

II. ASSESSMENT – ANNUAL

It would be a misnomer to call this annual update a comprehensive assessment of the health and well being of the community. Lack of funding has prevented the Department from completing this kind of critical assessment of the health status of the community. Such an undertaking would need to be funded at levels comparable to those provided to the local Commissions on Children and Families. Therefore this document will provide a global overview of the public health related issues faced by the community, in the framework of the ten essential public health services or areas of concern.

J. DESCRIPTION OF PUBLIC HEALTH ISSUES AND NEEDS IN KLAMATH COUNTY

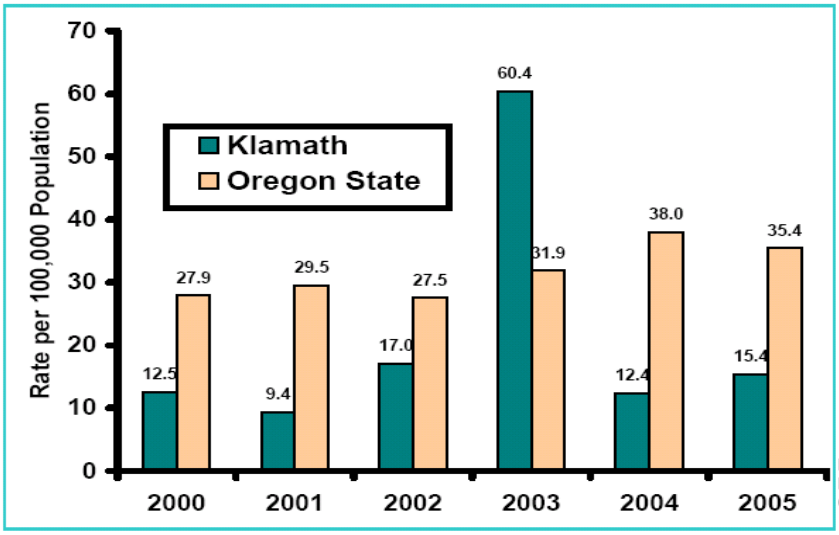
1. Communicable, Infectious and Vaccine-Preventable Diseases:

a) Hepatitis C continues to be of great concern in the community. Our struggle is reaching this high risk population and getting them in for testing.

b) Enteric pathogens such as noroviruses continue to occur in outbreaks in our population, demanding intensive and time-consuming investigations to determine source of infection. Although the number of outbreaks declined in 06-07, the numbers of persons affected increased,

c) Even though Klamath County is relatively rural, we have predicted the possibility of imported diseases occurring here, with an ever-increasing mobile population engaged in international commerce (i.e. Jeld-Wen Inc., Masami Foods), as well as military travel in and out of our Kingsley Air Base.

d) Except for the year 2003, our vaccine preventable disease rates were significantly lower than the States, reflecting better immunization rates and lower exposure opportunities.



Vaccine-Preventable Disease Rates in Oregon State and Klamath County, 2000-2005

Includes H. influenzae, Hepatitis A, Hepatitis B, Measles, Meningococcal Disease, Mumps, Pertussis, Rubella, Tetanus

Data Source: Oregon Department of Human Services, Acute and Communicable Disease Prevention.

2. Child and Youth Well Being Health Issues:

a) As in national findings, Klamath County's elevated poverty rates and low rates of advanced education correlate with a variety of poorer health indicators, the most troubling of which is Klamath County's current ranking of third worst in the State on the OREGON BENCHMARKS' Child Well-Being Index, the most significant public health issue in Klamath County.

b) According to an analysis by the Office of Community Health and Health Planning in April of 2007, Klamath County's infant mortality rate of 8.8% over the last three years is significantly higher than the State average, higher than the rural average and trending worse. This finding is attributed by the Office of Community Health in large part to Klamath County being ranked second highest in the State for alcohol and other drug use during pregnancy. This continued elevation in our infant mortality rate is recognized as a priority public health concern in our county, calling for a public health investigation and the development of a community action plan. Low Birth Weight rates of 8.1% for our county in 2007 are higher than the State rate of 6.1% for the same year. This finding also demonstrates a need for action. Rates of prematurity for Klamath County at 8.5% are comparable to the State rate of 8.4% for the same time period.

c) Teen pregnancy rates in Klamath County continue to show an increase. At present, our rates are over the state average. Despite our efforts in preventing unintended pregnancies, our rates have continued to increase over the last three years. One attributing factor to this may be federal regulation requiring teens to provide proof of documentation, i.e., Birth certificate, social security card, and picture I.D. Although the services are still available to teens through other funding sources, the word among the teen population is that now you need these documents to acquire our services.

d) Other Klamath County youth risky behavior reports reflect need for concern and intervention. According to the *Alcohol, Illicit Drug & Tobacco Consumption Report, In Klamath County*, 2000-2006, Klamath County 8th graders surveyed in this period reported increasing occasional use of alcohol to a new high rate of 35%, and an increase in gambling rates to 31%. Occasional alcohol use among surveyed 11th graders reached a new high of 57% in 2006, while gambling rates dropped to 37%. Tobacco use by 8th graders, while still higher than other rural counties as well as the State average, does show the signs of improvement that adequate funding can produce.

3. Family Well Being Health Issues:

a) Families in Klamath County continue to experience high rates of distress associated with their poverty status. More than 30% of families in Klamath County continue to be plagued by the stresses of being under 100% of the Federal Poverty Level. In spite of millions of dollars spent to assist economically and socially disadvantaged

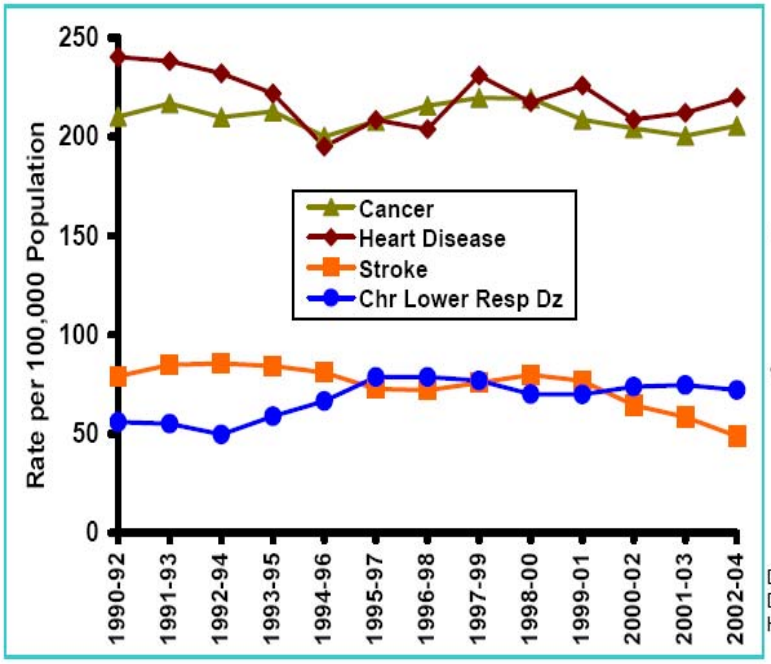
families, poverty remains an intractable problem due to the lack of "family wage" jobs and the ability to compete successfully for them.

b) Traditional, self reliant, industrious "farm values" prevail among the families who have lived in the County for several generations. The Latino population and culture, with its strong traditions of family orientation, is having the largest impact in the Basin and in the population growth in younger age groups.

4. Aging Populations Well Being Issues:

a) The post 65 population in Klamath County demonstrates the most economically secure segment in Klamath County comparable with the rest of the State. In-migration is composed of relatively affluent retirees and well educated middle aged couples with either enough income to afford a second home or able to take advantage of comparatively lower property prices in Klamath County. Correspondingly, more senior residents of Klamath County are able to maintain independent living arrangements than in the rest of Oregon.

5. Chronic Disease Morbidity and Mortality:



Age Adjusted Death Rates for Selected Chronic Disease in Klamath County, 1990-2004 rolling averages

Data Source: Death Certificates, Oregon Department of Human Services, Center for Health Statistics.

a) Local physicians anecdotally report increased numbers of overweight pediatric patients, a finding supported by YRBSS data, also. Lack of enough physical activity combined with poor diet obviously plays an important role in this growing problem. An alarming incidence of overweight in young children is being seen in our WIC program. The local program continues efforts in education regarding health diet, and has recently started physical activity promotion classes for kids.

b) As the graph indicates, Heart Disease is the leading cause of deaths in Klamath County. For the years 2004-2007, the prevalence of Coronary Heart Diseases was 4.9% compared to the state at 3.6%. For heart attached prevalence, Klamath County was at 5.7% which is statistically higher than the Oregon rate of 3.5%.

c) Significantly fewer deaths attributable to stroke are reported by Klamath County than the state. However, the stroke rate for the years 2004-2007 was slightly higher than the state at 2.5% compared to 2.3%.

d) The rate of cancer deaths was 204.8 (per 100,000) compared to Oregon's rate of 198.4 for the years 2000-2004.

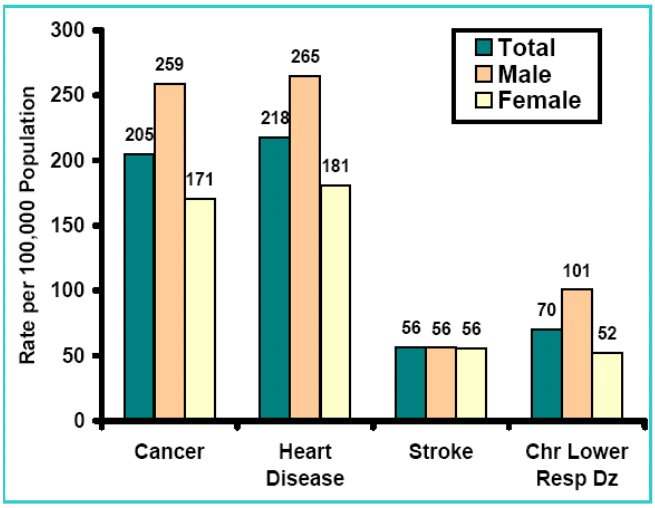
e) Klamath County's rate of chronic lower respiratory disease is significantly higher than the state at 70.5 (per 100,000) compared to the state rate of 49.1 (2000-2004). A history of unhealthy outdoor air quality in the Basin, couple with high smoking rates contribute to this phenomenon, but needs further epidemiological analysis.

f) Diabetes
As with the rest of Oregon, Klamath County has witnessed the development of an epidemic of overweight population during the past three decades. Local physicians report anecdotally that for the first time in their practice, they are seeing the expression of type 2 diabetes in youth, a finding also supported by the most recent Youth Risk Behavioral Survey problem of childhood and adult obesity increases, the incidence of Type II diabetes .An environment that is not conducive to year round outdoor activity and exercise limits opportunities for physical activity.

(1) We are concerned about the rate of obesity and Diabetes Millitus in Klamath County. Programs are promoted by Healthy Active Klamath Coalition in partnership with the Healthy Communities Program to promote the development of policies in the school, worksite and community that encourage "Making the Healthy Choice the Easy Choice."

6. Mortality Indicators:

a) Age adjusted death rates for stroke compare favorably with the state average however rates for heart disease, cancer, stroke and chronic lower respiratory diseases are higher than the state averages. Suicide, homicide and deaths from motor vehicle accidents reflect rates above the state average of the same years.

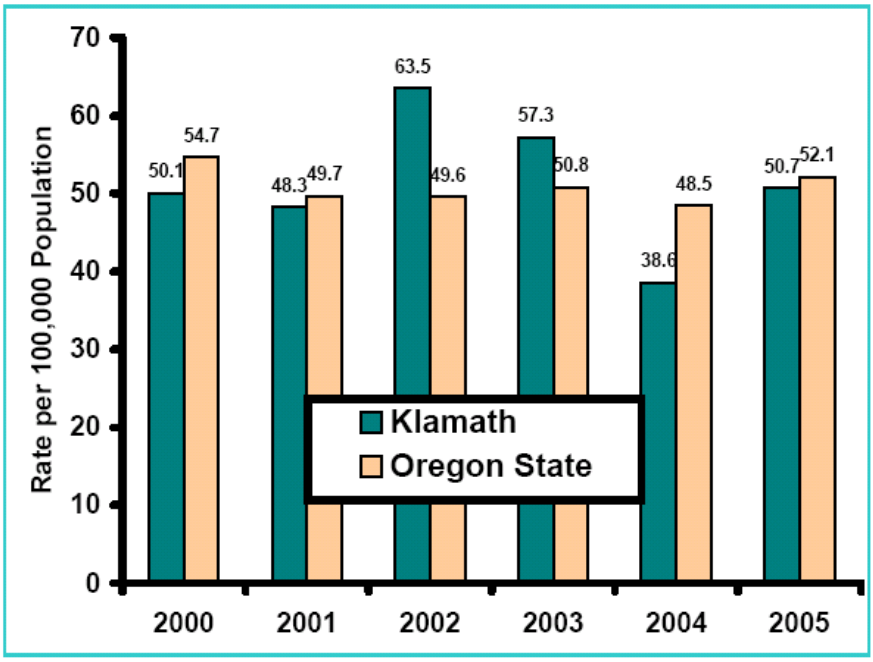


Age Adjusted Death Rates for Selected Chronic Disease By Gender in Klamath County, 2000-2004 average

Data Source: Death Certificates, Oregon Department of Human Services, Center for Health Statistics.

7. Environmental Health Indicators and Issues:

a) Food and waterborne disease rates for Klamath County for the years 2000-2005 show wide variation in incidence as the following chart from the Office of Community Health and Health Planning demonstrates:

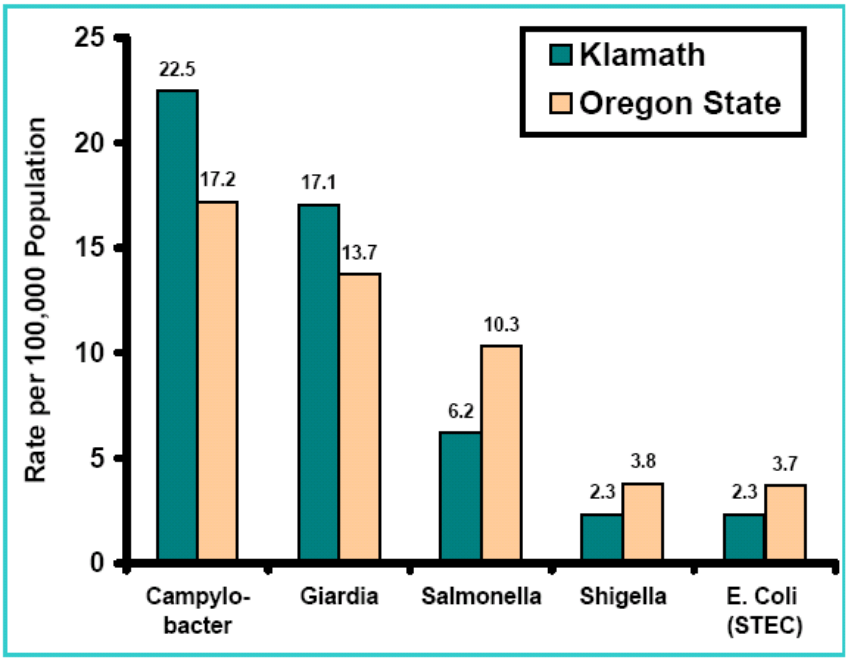


Food & Waterborne Disease Rates in Oregon State and Klamath County, 2000-2005

Includes Campylobacter, Cryptosporidium, Cyclospora, E. coli (STEC), Giardia, Listeria, Salmonella, Shigella, Vibrio, Yersinia

Data Source: Oregon Department of Human Services, Acute and Communicable Disease Prevention.

Rates of Selected Food & Waterborne Disease in Oregon State and Klamath County, 2000-2005 average



Data Source: Oregon Department of Human Services, Acute and Communicable Disease Prevention.

b) Rates of Campylobacter for Klamath County continue to surpass the rates for Oregon State. Cases reported have not been attributable to

either public food service or public drinking water supplies. We attribute the elevated number of Giardia cases to inadequate hand washing in daycare settings. Funding is not available for the preventive education that daycare settings in Klamath County warrant, but all cases in daycare settings receive a follow up investigation/education visit by Health Department staff to mitigate against reoccurrence.

c) We have noted an increase the number of maximum containment level violations in public drinking water systems. The increases have been noted in arsenic and nitrate. Shallow public wells in old lake bed areas have had difficulty in complying with the newer arsenic standards. Three (3) facilities have had elevated nitrate levels in their water. The concentration seems to fluctuate with the season making source identification more difficult. We attribute the increase in critical violations in our Food Inspection Program activities over the past five years primarily to increasing standards and better inspection activities. The lack of readily available aggregate data for these important environmental health indicators need to be addressed by the State of Oregon.

d) Outdoor air quality is viewed as the dominant environmental health issue in Klamath County, given Klamath County's designation of "Non-Attainment" with new federal air quality standards for very small particulate matter (PM 2.5). Unfortunately, the unintended effects of current Environmental Protection Agency regulations may actually inhibit local strategies to correct and eliminate the primary sources of this pollution from non-certified woodstoves. Officials predicted that "non attainment" status will produce an almost complete cessation of family wage job growth opportunities in the affected areas, which in turn will severely curtail the opportunity for working families to upgrade the wood fueled heating devices relied on for providing adequate warmth in the County's very cold winters.

8. Death by Intended and Unintended Injuries

a) **Suicide**
For nine of the past ten years, Oregon's suicide rate has exceeded the nation's by at least 25 percent. Data from recent studies indicate that suicide rates for 2002-2006 averaged 20 per 100,000 in Klamath County, versus a rate of 15 for the State as a whole. The suicide attempt rate for 8th grade youth is even with the State rate of 8%. It is commonly believed that these rates reflect the stresses of a large group of low income individuals and families compounded by their self-medicating behavior.

b) **Motor Vehicle Accidents:**
The significantly high motor vehicle death rate in Klamath County is largely associated with impaired driving. Twice as many motor vehicle fatalities in Klamath County were related to alcohol as in the rest of the State.

9. Preventable Deaths and Injuries:

a) The rate of alcohol related deaths has nearly doubled in the past decade in Klamath County, now representing 2.47% of all deaths in Klamath County. The tobacco-related disease death rate for Klamath

County in 2009 was 26%, over the state rate of 22%. It is hypothesized that lack of access to adequate medical care is affecting this rising trend, but further epidemiological analysis is needed.

10. Drug, Alcohol Abuse and Crime:

a) The Oregon Benchmarks rank Klamath County above the State average in public safety (14th out of 36 counties.) Personal crime rates in Klamath County exceed both rural and state rates, according to data from the Oregon Benchmarks, but Klamath County is significantly lower than these other entities in both property and behavioral crimes.

b) According to the Klamath County Drug Task Force, Klamath County experiences a high rate of methamphetamine related crime, representing about 75% of all drug offenses during 2004-2005. They report a continuing downward trend from previous years.

c) A United Way survey completed by approximately 600 Klamath County residents placed substance abuse second only to child abuse as the leading causes of community concern.

11. Mental Health

a) We continue to see many family planning clients with mental health issues, primarily depression. The 9-1-1 Call Center reports that they have observed an increase in the numbers of calls from persons in psychological distress over the past several years. These calls are attributed to the increase in the numbers of residents without mental health insurance, as well as difficulty in accessing appropriate and consistent mental health resources. Klamath County does have an access center for patients in need of immediate assistance. Klamath County Mental Health opened their new building to be used for Mental Health Services. The site of this building is much more accessible than the previous site. Mental Health also sees a high number (estimated at 50%) of their total patients who have dual diagnosis of Mental Health / Substance Abuse (primarily methamphetamine).

K. DESCRIPTION OF THE ADEQUACY AND EXTENT OF THE FIVE BASIC PUBLIC HEALTH SERVICES AND OF THE EXTENT TO WHICH THE LOCAL HEALTH DEPARTMENT PROVIDES THE FIVE BASIC SERVICES CONTAINED IN STATUTE (ORS 431.416) AND RULE

1. Epidemiology and Control of Communicable Diseases and Preventable Hazards:

a) Klamath County provides above average epidemiology and control of communicable diseases. Since our last triannual review, the Department was presented with a major tuberculosis outbreak affecting several hundred people at a local meat processing plant, which we handled with additional resources from the State TB program. During the same period, our Communicable Disease staff and Environmental Health staff collaborated in investigation and stopping the transmission of a norovirus, which also sickened several hundred people at a popular local food facility. Both of these interventions were supported with the availability of public health

preparedness funding, plus emergency funds from the Oregon Public Health Division. Reoccurrence of similar outbreaks, such as the H1N1 event, will threaten the stability of Departmental operations, unless such events can be similarly funded.

b) Program reviews have found the Communicable Disease program is in compliance with State and CLHO standards, except for minor delays in reporting. Changes in the Communicable Disease Coordinators schedule will help to resolve this issue. The loss and restoration of Klamath County's Secure, Rural School funding has and will continue to have a critical impact on communicable disease program staffing. But due to lack of funding, we are unable to perform the level of proactive interventions needed to slow our elevated rates of Hepatitis C.

c) All clinical nurses have completed at least Epidemiology 101, and are well versed in communicable disease outbreak investigation and control measures. This includes reporting, monitoring, investigation, treating, and preventing further illness. We work closely with local health care providers, and the Oregon's State epidemiologists and Oregon State Lab, as referenced above.

d) Klamath County Health Department provides immunizations against common preventable diseases as required by statute and rule. Childhood vaccinations and adult vaccinations are given as indicated and desired. For quality assurance and efficiency purposes, patients can access immunizations by appointment for all of the state and federally mandated public health services including communicable disease, childhood and adult vaccinations.

e) Since our last triannual review, the Department has continued to assure a steadily increasing rate of County two-year-olds up to date on recommended vaccination schedules over the state-wide average. We are continuing raising our immunization rates in effort to meet the Healthy People 2010 goal of 90%.

f) Our school exclusion rate for unimmunized or under immunized children continues to decline, from 543 exclusions in 2005-06, 387 exclusions in 2006-07, and 254 exclusions in 2007-08.

g) **Ryan White Case Management -** There are currently 23 people living with AIDS in the community that take part in the Ryan White Case Management program, up from 12 participants just three years ago.

h) **HIV Testing -** While we have always offered HIV testing and counseling, we are not receiving funding for this program for the next fiscal year. This will limit the number of no charge tests we are able to provide.

i) **Sexual Transmitted Infection Program** - Men and women can access testing for sexually transmitted infections in a timely manner. Clients with symptoms are seen promptly by a trained RN or NP. In 2009, a total of 152 Chlamydia cases and two (2) Gonorrhea cases were identified and treated. Local medical professionals also report other STI's and we initiate treatment and partner treatment if not already done.

j) **Immunizations -** Klamath County's most recent childhood immunization rates, for 2009-2010, are that 76.9% of 24-35 month olds are fully covered with the 4:3:1:3:3:1 series. We are continuing efforts to meet the Healthy People 2010 goal of 90%. Our school exclusion rate for unimmunized or under immunized children shows 543 exclusions in 2005-2006; 387 exclusions in 2006-07, 254 exclusions in 2007-08, 127 exclusions in 2008-09 and 129 exclusions in 2009-2010. This shows a steady decline in the number of children needing immunizations to stay in school, and again is making strides to making the goal of 90% completely immunized by 2010.

k) Klamath County Health Department provides immunizations against common preventable diseases identified as being required childhood vaccinations, and adult vaccinations as indicated and desired. Patients can access immunizations by appointment all of the state and federally mandated public health services including communicable disease, childhood and adult vaccinations, family planning services, and environmental health services.

l) The nurses have all completed at least Epidemiology 101, and are well versed in communicable disease outbreak. This includes reporting, monitoring, investigating, treating and preventing further illness. We work closely with local health care providers, and the Oregon's State epidemiologists and Oregon State Lab.

2. Parent and Child Health Services

a) **Family Planning:**

(1) The Klamath County Health Department provides a full range of family planning services to all women of childbearing age who have not had permanent sterilization. In addition to well-woman exams and discussion and distribution of birth control methods, we offer IUD/IUS inserts, colposcopy, endometrial biopsy, and cryotherapy. We are working to include men in the family planning program, since at 0.3% currently we are below the state rate of 2.6%. One of our goals is to increase male utilization of family planning services.

(2) Klamath County Health Department provides excellent family planning services to the entire community in need. Unfortunately, we find the ever increasing federal regulations cost prohibitive to implement at the rate we are being reimbursed from family planning grants and fees. We look forward to consultation with the Office of Family Health Services to identify acceptable strategies to reduce the high rate of local subsidy of this program.

(3) The Health Educator also goes to the City Schools and speaks to new teen parents about family planning in an effort to prevent subsequent pregnancies.

(4) Pregnancy testing is available Monday through Friday on an appointment or walk-in basis. Women who have a positive pregnancy test are counseled regarding all of their options, and referred to other agencies including Oregon Health Plan, medical care, and WIC, or termination services. Women who

have a negative pregnancy test are given birth control options, often to start immediately. They are referred for further family planning services or other medical interventions based on need.

(5) Family Planning clinics offer a full exam including breast exam and pelvic, PAP smear and screening for sexually transmitted diseases. This clinic is offered 2 ½ days per week. The late afternoon hours are designated for teens so that they may access care after school. Birth control methods are discussed and dispensed, along with condoms for STI prevention.

(6) One of the challenges we have been facing this past year is the requirement that all family planning participants show proof of citizenship. This can be very difficult for adolescents seeking confidential services. We have three (3) notaries on staff to assist teens in getting a copy of their birth certificates.

b) **Prenatal Care**

(1) Pregnant women are more likely to begin prenatal care in the first trimester if they have insurance. The Klamath County Health Department is able to offer pregnancy testing on-site and provide a date-stamped application for the Oregon Health Plan to assist women in getting insurance and into prenatal care. In Klamath County, over half of the births are paid for by the Oregon Health Plan. Additionally, education is provided about nutrition, drug, alcohol, tobacco and other lifestyle issues during pregnancy and facilitates pregnant women to access WIC services. Pregnant women are also provided a referral list of prenatal care providers.

(2) We received an $18,000.00 grant from March of Dimes to provide 5 A's training to prenatal care providers to reduce the rates of women who continue to smoke during pregnancy.

(3) Approximately 22 women are referred to the Oregon Health Plan each month.

c) **Early Childhood Public Health Interventions**

(1) Klamath County has a high rate of low birth weight babies: 84.1 / 1000 births compared to the State average of 61/ 1000 births for the year 2007. In addition, the department has observed an unusual number of infants identified with anomalies before the first birthday. These occurrences have produced a consistent demand for nearly 2.0 public health nurses to provide both Babies First! and CaCoon services to over 275 unduplicated clients in 2007. OHSU Pediatric Cardiology offers quarterly clinics in Klamath County that are always fully booked.

(2) Dental disease is the most prevalent chronic health problem among children in Oregon, five times more common than asthma. Oral health problems have routinely been identified as the largest unmet health need in Klamath County. In 2002, Klamath County received a Robert Wood Johnson grant to provide pregnant women with free dental screening and repair

of their teeth, as well as education about baby bottle mouth and decay. Additionally, infants were screened from the time of tooth eruption to the age of two and treated with fluoride varnish as needed. The participants in this program were recruited from the WIC program in a very successful collaboration, for which Klamath County received national attention and recognition. More than 90 percent of the children who participated in this early prevention program have remained cavity free. The National Institutes of Health have awarded funding to replicate this community collaboration in four other rural Oregon counties over the next five years.

(3) The Lead Free Klamath Kids Project is a Klamath County Public Health Program funded by a $50,000 grant from the Environmental Protection Agency. The grant period was from 10/01/2007 through 09/30/2009. The parameters of the grant identified children at 1 year of age who lived in pre-1950 housing at the time of birth and offered free tests for lead exposure to them and their siblings aged 5 or younger. The goal of the grant was to screen 480 families and test 96 children. During the grant period, 963 families were screened and 247 children were tested. Testing was performed by a Registered Nurse via capillary sampling for blood collection. Klamath County is proud that we exceeded the parameters of the grant and that the testing goal was reached in the first 8 months of the grant period.

(4) The Klamath County Health Department offers home visiting programs for high risk infants in the community. The Babies First! Program identifies infants born at risk for developmental delay and provides services to these families according to program guidelines. Risk of developmental delay can be from medical factors, social factors or a combination. A new component of the program allows for a one-time, short-term intervention with families to increase their awareness of and ability to access community resources. This program is administered by The Office of Family Health through all Oregon county health departments. The CaCoon Program provides services to families who have children with special health needs per program guidelines. The target age is birth up to 21 years of age with the priority being infants born with special needs or children with newly diagnosed conditions that meet program elements. The outreach nurse, in both programs, coordinates and collaborates with local health care providers and other community agencies to help meet the needs of the family.

3. Environmental Health

a) Food Safety

(1) The Department licenses and inspects approximately 250 food facilities annually, as well as nearly 100 temporary non benevolent events. Since our last triannual review, staff reassignments have assured that we are in compliance with quantitative and qualitative inspection standards. We continue

to see a steady increase in food facilities with staff fluent only in Spanish, which creates concern for adequate communication regarding food safety issues.

b) **Air Quality**

(1) Air quality advisories are in effect between mid October and mid March annually. In the past, we have averaged more than 20 days of poor air quality, primarily attributed to wood burning with non certified appliances. Klamath County is in violation of federal regulations when poor air quality days exceed two annually, as measured by an air quality monitor at one of the local Klamath Falls elementary schools. We are working with Oregon Department of Environmental Quality to develop and implement a plan for compliance by 2012.

c) **Safe Drinking Water**

(1) Klamath County has over 140 EPA Regulated Public Water Supplies. Many of these are small systems serving seasonal operations, campgrounds, small businesses and small housing developments. While most of the county's population is served by a public system, there are many private residential systems. Some of these small systems obtain their water from shallow aquifers that are maintained by leakage from the irrigation canal system. One small community does not have a community water system and its residents depend upon shallow wells that are easily contaminated. With the addition of State regulated drinking water systems, our Environmental Health division now regulates over 170 public drinking water systems annually.

d) **Liquid and Solid Waste**

(1) Klamath County has an active program dealing with Onsite Sewage Treatment and Disposal for those flows less than 2500 gallons per day and of the strength equal to or less strong than residential waste. Onsite sewage flows greater than 2500 gallons per day or of a stronger than residential strength is regulated by the Department of Environmental Quality. The poor economy has resulted in fewer new system installations, some repair of existing systems and a reduction in onsite visits by staff.

e) **Travelers Accommodations, Organizational Camps, and Public Swimming Pools and Spas**

Klamath County has 52 motel/hotels, 33 recreation (RV) parks and six organizational camps. The hotels/motels are inspected biannually, the recreation parks semi-annually and the camps annually.

(1) Klamath County has a total of 35 public swimming pools and spas. Eighteen are operated year round and the others are operated seasonally. The year round facilities are inspected

semi-annually, the seasonally facilities are inspected once during the season. Follow up inspections are made as needed based upon the violations observed.

4. Health statistics

a) Collection and Reporting

(1) Birth and death certificates are collected and recorded, and pertinent information is relayed to the Oregon Health Division. Birth and death certificates are available to family members who require these for services – often within 24 hours. We have two (2) employees on staff certified to provide these certificates.

b) Medical Examiner

(1) Klamath County has contracted with a new regional medical examiner during this triennium, and employed an experienced deputy medical examiner to augment the services. Autopsies are now performed locally more frequently and with better reporting. But, we have been unsuccessful in obtaining state reimbursement to offset the costs of autopsies, which results in another unfunded mandate for cash-strapped local government.

5. Information and Referral

a) **Health Education**

(1) In addition to providing information and referral service to the public nine (9) hours per business day, we employ three (3) Health Educators that provide information and education about the My Future My Choice Program, Tobacco Prevention and Education Program, Chronic Disease Prevention, Safe Routes to School Program, hygiene, family planning services and the services offered at the Klamath County Health Department.

(2) We enjoy a good rapport with the local media and have utilized them to get health messages to the public. The health department lobby has a large bulletin board that the Health Educator updates at least monthly with information about timely topics.

L. OTHER - DESCRIPTION OF THE ADEQUACY OF OTHER SERVICES OF IMPORTANCE TO THE COMMUNITY

1. Nutrition and Physical Activity

a) The WIC program continues to be our flagship program in providing trusted nutrition and other health information and education, assessment and referrals to families under 185% of the FPL. Pregnant women and children at high nutrition risk are referred to a Registered Dietician for individual counseling. Nutrition based classes are offered approximately weekly.

b) A nutritional assessment is completed for family planning clients, and dietary changes are suggested if needed.

c) Being overweight continues to be a significant problem for many of our younger and poorer clients. The Klamath County Public Health Department is the lead agency for the Healthy Active Klamath Coalition (HAK). HAK has been funded by health care trusts in the past several years to develop successful strategies to improve the nutritional and physical status of the entire population, but particularly of those at most risk of developing chronic diseases.

2. Emergency Preparedness

a) This department has made major strides in integrating itself into the general Emergency Management and Emergency Services Community during the past few years. Regular communications occur between departments, we regularly attend meetings of various emergency agencies, are included in multi-agency plans, routinely participate in multi-agency exercises, etc. Other agencies routinely include Public Health in their thought processes and planning. Concurrent with these activities is a major realization by the Public Health Department staff of the changing role of Public Health. A well-functioning public health emergency notification system is in place. Participation in the Oregon Health Alert Network is active and up to date, with regular testing occurring. We are in the process of integrating our activities with the incident management activities of the county as a whole. This includes our participation in the establishment of a local Type III Incident Management Team.

3. Older Adult Health

a) The Klamath County Health Department does not offer health services specifically targeted for older adults. We do, however, orchestrate the provision of flu vaccine availability for older persons and others with immune suppressed status. If additional unrestricted funding should become available, we are entertaining the merits of fostering a “freedom from in-home falls” for the more vulnerable elderly in our communities.

4. School Based Health Clinic

a) Klamath County recognizes the effectiveness of making health care available where children are; the schools. We have a school based health clinic in, Gilchrist, Klamath County, providing quality comprehensive care to K-12 school children and their preschool siblings.

b) During the 2009-2010 school year, the SBHC had 174 visits.

c) We meet quarterly with a citizen advisory group in Gilchrest to discuss operations of the SBHC.

5. **Partners**

a) Klamath County is a close knit community and we are fortunate to partner with several agencies in providing comprehensive services to our clients. We are able to date-stamp Oregon Health Plan applications to ease access to prenatal care for pregnant women. Our local Federally Qualified Health Center (FQHC), Klamath Open Door Family Practice, shares referrals with us and assists us in helping meet the needs of our clients. Oregon Health Sciences University has a family practice residency program for physicians and a nursing school in Klamath Falls. The health department is able to serve as a training site for new physicians and nursing students.

b) In the Environmental Health Division of the department, partnering occurs with the US EPA, Oregon Department of Environmental Quality (DEQ,) Oregon Department of Forestry (ODF,) the US Forest Service, Oregon Department of Education, Oregon Department of Labor, County and City School Districts, and local Fire Districts.

6. Dental

a) Dental infection continues to be a major problem in Klamath County. Klamath County also has only one dentist per 2200 persons, which makes access to care very difficult for our citizens, even with the added resources of community health centers. Lack of dental care is routinely the most needed, least available health care service identified in every community health survey conducted. Klamath County has continued its nationally recognized work to prevent the transmission of strep mutans infection from mothers to infants. Data from the Robert Woods Johnson grant we received demonstrate that to date 96% of the mothers who participated in the model program have cavity free children at ages two and three.

M. ADEQUACY OF BASIC SERVICES: ***NO CHANGE IN STATUS EXCEPT AS REFERENCED IN EXECUTIVE SUMMARY***

III. ACTION PLAN

N. EPIDEMIOLOGY AND CONTROL OF PREVENTABLE DISEASES DISORDERS

Goal: Continue to control all communicable/reportable diseases through prompt investigation, with needed interventions and public education.

1. **OBJECTIVE 1:** The Klamath County Health Department will continue providing timely epidemiological investigations of reportable conditions per OAR 333-018-0015.

a) **ACTION PLAN:**

(1) Assigned and relief Communicable Disease PHN will review submitted reports daily, print investigative report and guidelines from ODHS website and complete investigative report per the guidelines.

(2) Assigned and relief Communicable Disease PHN will contact affected individuals, their care providers and families as needed for investigation, to provide education, ensure correct treatment and follow up.

(3) Assigned and relief Communicable Disease PHN will submit completed investigation forms to ODHS Epidemiology department per established time line (90% of case forms submitted weekly).

b) **EVALUATION:**

(1) Quarterly audits of Disease Investigations will be done by QA Coordinator to check for time/date of initial report, investigation initiation, client contact, notification of ODHS Epidemiology, completion of form and submission to ODHS

(2) All members of the clinical nursing staff will continue participating in current communicable disease training made available via regional sessions facilitated by Oregon Health Services (OHS) such as CD 101; distance-based learning such as CDC web or netcast; CD-Rom ("Botulism in Argentina"). All employees with occupational exposures will participate in Blood Borne Pathogen training annually.

(3) The clinical services coordinator will maintain a log of CD continuing education training and Blood Borne Pathogen completed for integrating record into annual performance evaluation and review.

2. **OBJECTIVE 2:** To improve reporting practices by local private providers that will continually improve surveillance and investigative efforts.

a) **ACTION PLAN:**

(1) The Communicable Disease Coordinator will provide education/information to all local medical providers on communicable disease reporting. Annually, an explanatory cover letter accompanying a confidential morbidity report form will be sent to each provider, with follow-up by the Communicable Disease Coordinator either in person or by phone. Results of contacts will be logged.

b) **EVALUATION:**

(1) Annual review of timelines of morbidity reports from private providers.

3. **OBJECTIVE 3:** Improve community awareness regarding emergency CD issues.
   a) **ACTION PLAN:**
      (1) The Communicable Disease Coordinator will actively promote educational outreach activities via contact with service organizations, medical providers, interest groups and special populations. The CD Coordinator will collaborate with the Health Officer to publish local articles regarding issues at least annually in the local newspapers or electronic media.
   b) **EVALUATION:**
      (1) Communicable Disease PHN will report on accomplishments at annual personnel evaluation.
4. **OBJECTIVE 4:** Address problem of lack of testing/ follow up in populations at high risk for Hepatitis C.
   a) **ACTION PLAN:**
      (1) The Klamath County Health Department will continue screening and offer testing to high risk populations for Hepatitis C through available grant funds.
   b) **EVALUATION:**
      (1) Documentation of a 10% increase in testing for Hepatitis C in high risk populations annually by QA Coordinator.

B. PARENT AND CHILD HEALTH SERVICES, INCLUDING FAMILY PLANNING CLINICS AS DESCRIBED IN ORS 435.205:

As referenced elsewhere throughout this document, our parent and child health services have been judged as excellent by a variety of reviewers. But as excellent as they are, these programs on their own are not adequate to address the scope of the social problems driven by the scale of the culture of poverty here in Klamath County. The Department intends to stay actively involved with other proven and demonstration efforts to address the root problems which contribute to Klamath County's abysmal rankings in the well being of its younger populations by the Oregon Progress Board.

We would welcome the opportunity to replicate the success of the Olds Home Visiting model as our expert contribution to the community's primary prevention efforts, so we remain hopeful that the Nurse-Family Partnership initiative will be funded in Oregon.

Over the next three years the Department will explore how we can build on and leverage the successes of both our Family Planning and WIC programs to improve our progress toward attainment of Healthy People 2010 Maternal and Child Health objectives.

One opportunity that we will evaluate will be whether our direct provisions of early prenatal care to our poorest populations will improve our low birth weight outcomes by reducing alcohol and tobacco usage during pregnancy. Klamath County Health Department has received a grant from the March of Dimes, Greater Oregon Chapter to provide training to local providers who provide obstetrics and their staff to

implement the 5 A's model of smoking cessation. A 5 A's training will take place for the providers to assist them in implementation. Recent longitudinal European studies evidence the correlation between birth weight and susceptibility to later stage chronic diseases. These studies provide a compelling argument for communities to undertake as a priority health initiative a comprehensive campaign to ensure all birth weights for term pregnancies meet or exceed 2500 grams. We will seek grant funding to analyze the causes and research best practices to improve our low birth weight phenomenon, and, if appropriate, develop a business plan by 2011. If the private health care community can support our plan, we expect that a serendipitous result of our adding health care staffing will be to increase medical provider capacity for other populations in need. During this timeframe we will continue to provide our mandated parent and child health services to the extent possible with approved funding levels.

B1. FAMILY PLANNING SERVICES

1. **OBJECTIVE 1:** To offer and provide clinical, informational, educational, social and referral services to anyone of reproductive age requesting family planning and reproductive health care. In addition to the Annual Family Planning plans that have been and will be submitted annually under separate cover, the Klamath County Public Health Department continues to:

   a) **ACTION PLAN:**

      (1) Through staffing changes, secure compliance with the remaining Family Planning Grant requirement to provide each client documentation of her/his visit costs and the fees assessed for those costs to the client.

   b) **EVALUATION:**

      (1) Office manager will assess compliance annually at the close of the fiscal year.

B2. IMMUNIZATIONS - (See attached plan, page 41)

B3. WIC - (See attached plan, page 54)

B4. BABIES FIRST! - Will continue to offer and provide comprehensive services to all infants and children at risk for developmental delay.

1. **OBJECTIVE 1:** Developmental screenings will be completed at 4, 8, 12, 18, 24 and 36 months of age to identify all children in the Babies First! And CaCoon Programs with developmental delays and that their families will receive appropriate interventions for their child's condition.

   a) **ACTION PLAN:**

      (1) PNN's working in Babies First! And CaCoon will receive instruction on the use of the ASQ and the ASQ-SE

      (2) Clients enrolled into the Babies First! Program will be screened using the required program screening tools for the age of the child being screened. Babies First! provides services to children birth through 59 months of age. The Babies First! High Risk Infant Tracking Reference Tool designates the screens required at each milestone

         (a) The PHN will do an initial assessment from birth to six weeks or at any age the child is referred into the program

         (b) Developmental screens can be done within a month before, during, or after the 4th month, 8th month, 12th month, 18th month, 24th month, and 36th month, and are now able to screen though 59 months, or until the child is discharged from the program. The DOB or the CDOB will be used to determine when the developmental screenings will be completed per program protocol. Screenings with questionable results will be rescreened according to program guidelines

      (3) The home environment will be evaluated for issues causing delays in development

      (4) The PHN will work with the families to improve the development of any child with environmental issues causing impact on development

      (5) The PHN will refer families with a child with altered growth and development (as determined by the scores received on the screening tools) to Early Intervention unless the family declines the referral. The PHN will provide anticipatory guidance to those families who decline a referral for further evaluation

      (6) The PHN will monitor the family's ability to access needed resources and monitor their compliance and follow-through with recommended referrals

      (7) Babies First! And CaCoon charts will include documentation of developmental assessments according to HRI protocol and will reflect the consistent recording of weight, height, and weight/height as part of the child's assessment.

   b) **EVALUATION:**

      (1) Conferences as needed with home visit nurses on caseload issues and concerns

(2) Annual ORCHIDS data assessment

(3) Quarterly chart review by MCH nursing services coordinator.

B5. **MATERNAL, INFANT, CHILD AND ADOLESCENT HEALTH PERINATAL GOALS:** Focus perinatal funding on documented interventions with pregnant women to ensure their compliance with best dental practices to eliminate oral infection at time of delivery.

1. **OBJECTIVE 1:** 10% of Klamath County WIC enrollees on the Oregon Health Plan will participate in assessment/treatments to eliminate oral infection while pregnant.

   a) **EVALUATION:**

      (1) Monitoring of annual Klamath County numbers of OHP pregnant eligibles and number of Klamath County OHP pregnant women receiving a dental visit annually.

2. **OBJECTIVE 2:** Replicate RWJ funded project with the University of Washington in four other rural Oregon counties.

3. **OBJECTIVE 3:** Continue to lead, participate in community collaborations to reduce alcohol, tobacco use by pregnant women to Oregon Rural Benchmark.

   a) **ACTION PLAN:**

      (1) Increase support for women who are pregnant and trying to quit tobacco and alcohol by offering educational materials and support through local physician's offices.

      (2) Use funding secured through the March of Dimes, Greater Oregon Chapter to provide training to local providers who provide obstetrics and their staff to implement the 5 A's model of smoking cessation. A 5 A's training will take place for the providers to assist them in implementation.

      (3) Continue to educate women in WIC and during pregnancy testing about the importance of smoking cessation and the health of their infant.

      (4) Collaborate with Klamath County Mental Health department and substance abuse prevention intervention program to increase intervention and screening for women using drugs and alcohol during their pregnancies.

      (5) Provide information at all WIC visits and pregnancy check visits.

      (6) Provide support for women seeking help with substance abuse issues, including referrals for counseling, in and outpatient treatment.

   b) **EVALUATION:**

      (1) Secure funds for community campaign to reduce prenatal risks associated with low birth weight and infant mortality.

(2) Verify that women are receiving support, information and referrals on smoking cessation and substance abuse prevention

B6. ADOLESCENT HEALTH

1. **OBJECTIVE 1: C**ontinue to participate in Mental Health Department's collaborative to reduce teen suicide attempts and deaths to Oregon rate of 2.2 per 1000.

   a) **ACTION PLAN:**

      (1) Offer assessment and support during family planning and STI clinics

      (2) Collaborate with community partners to develop a written protocol for identification, intervention, and referral of suicidal youth.

   B) **EVALUATION:**

      (1) Review Klamath County youth suicide rate annually for trend analysis and send findings to Klamath County Mental Health.

2. **OBJECTIVE 2:** Improve adolescent health status in underserved communities by implementing school based health services

   a) **ACTION PLAN:**

      (1) Open school based health center in Gilchrist, OR in February, 2009.

   b) **EVALUATION:**

      (1) Annual certification of school based health center operation in Gilchrist.

C. ENVIRONMENTAL HEALTH GOAL: To provide all of the services mandated under ORS 446, 448, and 624 in addition to OAR 333-012.

C1. DRINKING WATER PROGRAM GOALS: To protect the public drinking water supplies for all Klamath County residents whose drinking water is provided by public water systems.

1. OBJECTIVE 1: To be in compliance with EPA and Drinking water priorities and protocols for EPA and state regulated systems by July 1, 2010.

   a) **ACTION PLAN 1**

      (1) Investigate and have a plan to bring into compliance within assigned timeline any water systems that are significant non compliers. Investigations and resolution will be documented according to state rules and protocols.

   b) **EVALUATION 1:**

      (1) Written confirmation by state drinking water authorities of recognized resolution of each significant non complier.

c) **ACTION PLAN 2:**

(1) In conjunction with the state drinking water program, develop a database to predict or identify and monitor any/ all locally regulated system testing problems. Regimen failures in order to assure compliance with requirements.

d) **EVALUATION 2:**

(1) Demonstration of database operation and use by July, 2009

e) **ACTION PLAN 3:**

(1) Conduct the assigned Water System Surveys each calendar or fiscal year.

f) **EVALUATION 3:**

(1) Review and count the number of surveys submitted for payment. Demonstration of database operation and use by July 2009.

C2. FOODBORNE ILLNESS PREVENTION PLAN GOAL: To protect the health of the public by preventing and investigating occurrence of food borne illness in public food facilities.

1. **OBJECTIVE** to bring LPHA program activities with compliance with state rules by maintaining performance of required inspections

a) **ACTION PLAN:**

(1) Perform re-inspection of facilities with critical violation within specified timelines.

b) **EVALUATION:**

(2) Quarterly review by EH program manager to ensure that all re-inspections did so occur.

D. **HEALTH STATISTICS GOAL:** To continue to collect, record and analyze birth and death information, issue certifications and monitor health status of county residents, in compliance with applicable state laws.

1. **OBJECTIVE 1:** Provide information pertaining to paternity affidavits to parents.

a) **ACTION PLAN:**

(1) Offer Rights and Responsibility DVD to all parents seeking birth certificates

b) **EVALUATION:**

(2) Annual review of log of parents who accepted or rejected DVD on Rights and Responsibilities.

2. OBJECTIVE 2: Registrar will send weekly reports of protected death information to the County Clerk's Office and send monthly reports of public death information to the County Assessor's Office.

a) **ACTION PLAN 2**

(1) Implement a log of death notices provided weekly to the clerk.

b) **EVALUATION 2:**

(1) Compare number of deaths in county with number of death notices provided annually.

3. **OBJECTIVE 3:** Maintain current service level during transition to electronic records and improve error rate on record.

a) **ACTION PLAN 3:**

(1) Review error rate at regular intervals.

b) **EVALUATION 3:**

(1) Records processed will have decreased possibility of human error due to the EDRS and EBRS system resulting in fewer queries and corrections.

(2) Compliance during the Triennial Review.

4. **OBJECTIVE 4:** Issue 100% of birth and death certificates accurately within 24 hours of request.

a) **ACTION PLAN 4:**

(1) Train all deputy registrars on the EDRS and EBRS system.

b) **EVALUATION 4:**

(1) All birth and death certificates will be issued within 24 business hours of request on corrected certificate.

E. HEALTH INFORMATION AND REFERRAL GOAL: Continue to provide timely and accurate health information referrals to Klamath County residents within 25 hours of request.

1. **OBJECTIVE:** Enhance clearing house function by identifying and sorting nature of calls logged.

a) **ACTION PLAN:**

(1) Create and enter key Information & Referral indicators into database for analysis by decision makers and possible program development.

b) **EVALUATION:**

(1) Annual review by LPHA Management Team.

F. OTHER ISSUES

F1. PREPAREDNESS will continue to develop and improve community emergency preparedness per PE-12 requirements.

1. **OBJECTIVE 1:** KCHD will complete all required PE-12 elements by date specified in contract.

a) **ACTION PLAN:**

(1) Preparedness Coordinator will attend monthly scheduled conference calls.

(2) Preparedness Coordinator will attend scheduled Region 7 meetings.

(3) Preparedness Coordinator will maintain local HAN user directory and ensure all user profiles are current

(4) Preparedness Coordinator will ensure identified KCHD employees have completed ICS courses- 100, 200, 700 and 800, as appropriate.

(5) Preparedness Coordinator will ensure all employee profiles are current in Learning Center

(6) Preparedness Coordinator, or designate, will test local HAN notification system quarterly.

b) **EVALUATION**

(1) Annual review by LPHA Preparedness Team.

IV. ADDITIONAL REQUIREMENTS:

The Klamath County Public Health Department and the Klamath County Commission on Children and Families have a cooperative and productive working and planning relationship. Both Departments are overseen by the Board of County Commissioners, which is also the Local Public Health Authority. Both Departments participate in the development of county human service priorities, based on mutually respected data and community input. The Health Department is the lead agency in the provision and analysis of data used by the Commission for relevant critical benchmarks.
The issues of the last triennial review are resolved.

V. UNMET NEEDS:

Like many other counties, the Klamath County Public Health Authority struggles to maintain mandated and needed services with decreasing funding from the State, and increasing costs of operation. Because of its size, the Family Planning program continues to be our "loss leader", requiring infusion of other funding because of its requirement that all family planning eligibles be provided the same level of comprehensive services, regardless of the clients' ability to pay, or the program's ability to fund the costs. Consequently, the Department has been forced to curtail its provision of newer, but costlier, reproductive methods.

Tuberculosis control funding continues to be woefully inadequate to manage the expense of even one active case per year. Immunization practice requirements cost this Department more than here times the amount of funding received from the State Immunization Program.

Reductions in the federal funding of public health preparedness programs have resulted in "trickle down" reductions of local preparedness funding, with ominous implications for the future of public health preparedness. All of these funding deficiencies are magnified by the absence of integrated state reporting systems, from cost accounting to electronic unduplicated program reporting.

Klamath County has historically had pockets of medically underserved or health care professional shortages. These shortages have recently "snowballed" into a crisis with the announced retirements and relocations of a number of local physicians (attributed to the anticipated uncompetitive federal reimbursement rates). The result of these shortages have exacerbated the deficiency in health care resources, with many practices unable or unwilling to accept new patients, or provide previous levels of uncompensated care.

Therefore, we have added a primary care goal in our plan to meet one of the assurances of the ten essential services: insure access to adequate primary care. Our objectives will to to continue its collaboration and leadership role in increasing the availability and accessibility of primary medical homes for all county residents.

Our action plan will be to continue participation in the Klamath County 100% Access Coalition's effort to provide basic health care insurance coverage for all residents. We will also continue to support the Klamath County Family Practices Consortium's planning to increase the number of health care providers practicing in the county. Recently, Sanford Pediatrics Clinic officials approved the building of a Sanford site in Klamath; we will continue to work with community partners to bring this world renowned pediatric practice to Klamath County.

Attaining compliance with the EPA standards for Particulate Matter 2.5 microns and smaller is a major concern for Klamath County. The major source of these emissions is old wood-burning stoves. These units are often in the homes of lower income residents who do not have the money to replace the stove. The stoves generally are very solidly built and last many years and are not replaced with more efficient and less polluting units. Unlike automobiles that are also a source of air pollution, wood stoves are not replaced because they do not wear out as rapidly as motor vehicles.

VI. BUDGET

(Budget and Projected Revenue information will be submitted under a separate cover)

Copies of the LPHA's public health budget can be obtained through the following contact information:

Mike Long, *Klamath County Tax Collector*
305 Main Street, Room 121
Klamath Falls, OR 97601
Phone: (541) 883-4297 | (800) 697-8087 | Fax: (541) 883-5165
http://www.co.klamath.or.us/tax/index.html

VII. MINIMUM STANDARDS

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

ORGANIZATION

1. Yes _✓_ No ___ A Local Health Authority exists which has accepted the legal responsibilities for public health as defined by Oregon Law.

2. Yes _✓_ No ___ The Local Health Authority meets at least annually to address public health concerns.

3. Yes _✓_ No ___ A current organizational chart exists that defines the authority, structure and function of the local health department; and is reviewed at least annually.

4. Yes _✓_ No ___ Current local health department policies and procedures exist which are reviewed at least annually.

5. Yes ___ No _✓_ Ongoing community assessment is performed to analyze and evaluate community data.

6. Yes _✓_ No ___ Written plans are developed with problem statements, objectives, activities, projected services, and evaluation criteria.

7. Yes _✓_ No ___ Local health officials develop and manage an annual operating budget.

8. Yes _✓_ No ___ Generally accepted public accounting practices are used for managing funds.

9. Yes _✓_ No ___ All revenues generated from public health services are allocated to public health programs.

10. Yes _✓_ No ___ Written personnel policies and procedures are in compliance with federal and state laws and regulations.

11. Yes _✓_ No ___ Personnel policies and procedures are available for all employees.

12. Yes _✓_ No ___ All positions have written job descriptions, including minimum qualifications.

13. Yes _✓_ No ___ Written performance evaluations are done annually.

14. Yes _✓_ No ___ Evidence of staff development activities exists.

15. Yes _✓_ No ___ Personnel records for all terminated employees are retained consistently with State Archives rules.

16. Yes _✓_ No ___ Records include minimum information required by each program.

17. Yes _✓_ No ___ A records manual of all forms used is reviewed annually.

18. Yes _✓_ No ___ There is a written policy for maintaining confidentiality of all client records which includes guidelines for release of client information.

19. Yes _✓_ No ___ Filing and retrieval of health records follow written procedures.

20. Yes _✓_ No ___ Retention and destruction of records follow written procedures and are consistent with State Archives rules.

21. Yes _✓_ No ___ Local health department telephone numbers and facilities' addresses are publicized.

22. Yes _✓_ No ___ Health information and referral services are available during regular business hours.

23. Yes _✓_ No ___ Written resource information about local health and human services is available, which includes eligibility, enrollment procedures, scope and hours of service. Information is updated as needed.

24. Yes _✓_ No ___ 100% of birth and death certificates submitted by local health departments are reviewed by the local Registrar for accuracy and completeness per Vital Records office procedures.

25. Yes _✓_ No ___ To preserve the confidentiality and security of non-public abstracts, all vital records and all accompanying documents are maintained.

26. Yes _✓_ No ___ Certified copies of registered birth and death certificates are issued within one working day of request.

27. Yes _✓_ No ___ Vital statistics data, as reported by the Center for Health Statistics, are reviewed annually by local health departments to review accuracy and support ongoing community assessment activities.

28. Yes _✓_ No ___ A system to obtain reports of deaths of public health significance is in place.

29. Yes _✓_ No ____ Deaths of public health significance are reported to the local health department by the medical examiner and are investigated by the health department.

30. Yes ✓ No ___ Health department administration and county medical examiner review collaborative efforts at least annually.

31. Yes _✓_ No ___ Staff is knowledgeable of and has participated in the development of the county's emergency plan.

32. Yes _✓_ No ___ Written policies and procedures exist to guide staff in responding to an emergency.

33. Yes _✓_ No ___ Staff participate periodically in emergency preparedness exercises and upgrade response plans accordingly.

34. Yes _✓_ No ___ Written policies and procedures exist to guide staff and volunteers in maintaining appropriate confidentiality standards.

35. Yes _✓_ No ___ Confidentiality training is included in new employee orientation. Staff includes: employees, both permanent and temporary, volunteers, translators, and any other party in contact with clients, services or information. Staff sign confidentiality statements when hired and at least annually thereafter.

36. Yes _✓_ No ___ A Client Grievance Procedure is in place with resultant staff training and input to assure that there is a mechanism to address client and staff concerns.

CONTROL OF COMMUNICABLE DISEASES

37. Yes _✓_ No ___ There is a mechanism for reporting communicable disease cases to the health department.

38. Yes _✓_ No ___ Investigations of reportable conditions and communicable disease cases are conducted, control measures are carried out, investigation report forms are completed and submitted in the manner and time frame specified for the particular disease in the Oregon Communicable Disease Guidelines.

39. Yes _✓_ No ___ Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or communicable disease case received.

40. Yes _✓_ No ___ Access to prevention, diagnosis, and treatment services for reportable communicable diseases is assured when relevant to protecting the health of the public.

41. Yes _✓_ No ___ There is an ongoing/demonstrated effort by the local health department to maintain and/or increase timely reporting of reportable communicable diseases and conditions.

42. Yes _✓_ No ___ There is a mechanism for reporting and following up on zoonotic diseases to the local health department.

43. Yes _✓_ No ___ A system exists for the surveillance and analysis of the incidence and prevalence of communicable diseases.

44. Yes ✓ No ___ Annual reviews and analysis are conducted of five year averages of incidence rates reported in the Communicable Disease Statistical Summary, and evaluation of data are used for future program planning.

45. Yes _✓_ No ___ Immunizations for human target populations are available within the local health department jurisdiction.

46. Yes ✓ No ___ Rabies immunizations for animal target populations are available within the local health department jurisdiction.

ENVIRONMENTAL HEALTH

47. Yes ✓ No ___ Food service facilities are licensed and inspected as required by Chapter 333 Division 12.

48. Yes ✓ No ___ Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.

49. Yes ✓ No ___ Training in first aid for choking is available for food service workers.

50. Yes ✓ No ___ Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided.

51. Yes ✓ No ___ Each drinking water system conducts water quality monitoring and maintains testing frequencies based on the size and classification of system.

52. Yes ✓ No ___ Each drinking water system is monitored for compliance with applicable standards based on system size, type, and epidemiological risk.

53. Yes ✓ No ___ Compliance assistance is provided to public water systems that violate requirements.

54. Yes ✓ No ___ All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken.

55. Yes ✓ No ___ A written plan exists for responding to emergencies involving public water systems.

56. Yes ✓ No ___ Information for developing a safe water supply is available to people using on-site individual wells and springs.

57. Yes ✓ No ___ A program exists to monitor, issue permits, and inspect on-site sewage disposal systems.

58. Yes ✓ No ___ Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.

59. Yes ✓ No ___ School and public facilities food service operations are inspected for health and safety risks.

60. Yes_✓_ No__ Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12.

61. Yes _✓_ No __ A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste. (We currently do not have a solid waste program at KCPHD. The program is administered by the Community Development Department.)

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. **(If within our authority-Yes, if not within our authority, referred to who might have authority.)**

64. Yes ___ No___ The health and safety of the public is being protected through hazardous incidence investigation and response. **(Not currently one of our activities, we are not funded, trained, or equipped to do this. Authority and responsibility are DEQ and Klamath County Fire District #1)**

65. Yes _✓_ No ___ Emergency environmental health and sanitation guidance are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control. (Except for solid waste disposal, shelter sanitation and vector control activities. Information and referral are provided for these.)

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. (ECCP)

70. Yes _✓_No ___ Local health department supports healthy behaviors among employees. (YMCA Membership)

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 **N/A**
    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.

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: **Marilynn Sutherland**

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: Partially**

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

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

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

AND

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

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

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

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

OR

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

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

d. Yes _✓_ No____ The local health department Health Officer meets minimum qualifications:

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

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

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. The Annual Plan posted at http://WWW.dhs.state.or.us/publichealth/lhd/lhd-annual-plan.cfm

is complete and current for our county

Marilyn Sutherland	Klamath County	09/22/10
Local Public Health Authority	County	Date

ATTACHMENTS

WIC Nutrition Education Plan FY 2010-2011	page 41
Immunization Plan - March 2008-April 2011	page 54

FY 2010 - 2011 WIC Nutrition Education Plan Form

County/Agency: Klamath County WIC
Person Completing Form: Sue Schiess
Date: 04/15/2010
Phone Number: 541-883-4276
Email Address: sschiess@co.klamath.or.us

Return this form electronically (attached to email) to: sara.e.sloan@state.or.us
by May 1, 2010
Sara Sloan, 971-673-0043

Goal 1: **Oregon WIC Staff will continue to develop their knowledge, skills and abilities for providing quality participant centered services.**

Year 1 Objective: During planning period, staff will learn and utilize participant centered education skills and strategies in group settings.

Activity 1: WIC Training Supervisors will complete the Participant Centered Education e-Learning Modules by July 31, 2010.

Implementation Plan and Timeline:

Our WIC training supervisor, Sue Schiess, will complete the PCE e-Learning Module by July 31, 2010

Activity 2: WIC Certifiers who participated in Oregon WIC Listens training 2007-2009 will pass the posttest of the Participant Centered Education e-Learning Modules by December 31, 2010.

Implementation Plan and Timeline:

Our WIC certifiers, Linda Frei, Gloria Tucker and Dora Hoffmeister, will pass the post test for the PCE e-Learning module by August 31, 2010.

Activity 3: Local agency staff will attend a regional Group Participant Centered Education training in the fall of 2010.

Note: The training will be especially valuable for WIC staff who lead group nutrition education activities and staff in-service presentations. Each local agency will send at least one staff person to one regional training. Staff attending this training must pass the posttest of the Participant Centered Education e-Learning Modules by August 31, 2010.

Implementation Plan and Timeline including possible staff who will attend a regional training:

We will send all our certifiers, who also teach class, Sue Schiess, Linda Frei, Gloria Tucker and Dora Hoffmeister to the regional Group Participant Centered Education training in the fall of 2010.

Goal 2: Oregon WIC staff will improve breastfeeding support for women in the prenatal and post partum time period.

Year 1 Objective: During planning period, each agency will identify strategies to enhance their breastfeeding education, promotion and support.

Activity 1: Each agency will continue to implement strategies identified on the checklist entitled "Supporting Breastfeeding through Oregon WIC Listens" by March 31, 2011.

Note: This checklist was sent as a part of the FY 2009-2010 WIC NE Plan and is attached.

Implementation Plan and Timeline:

We will continue to implement strategies as identified on the checklist entitled "Supporting Breastfeeding through Oregon WIC Listens" by March 31, 2011. Our first project will be to celebrate World Breastfeeding Week this year, as we have not been participating in this celebration for a couple years.

Activity 2: Local agency breastfeeding education will include evidence-based concepts from the state developed Prenatal and Breastfeeding Class by March 31, 2011.

Note: The Prenatal and Breastfeeding Class is currently in development by state staff. This class and supporting resources will be shared at the regional Group Participant Centered Education training in the fall of 2010.

Implementation Plan and Timeline:

In our breastfeeding education, we will include evidence-based concepts from the state developed Prenatal and Breastfeeding Class by March 31, 2011.

Goal 3: Strengthen partnerships with organization that serve WIC populations and provide nutrition and/or breastfeeding education.

Year 1 Objective: **During planning period, each agency will identify organizations in their community that serve WIC participants and develop strategies to enhance partnerships with these organizations by offering opportunities to strengthen their nutrition and/or breastfeeding education.**

Activity 1: Each agency will invite partners that serve WIC participants and provide nutrition education to attend a regional Group Participant Centered Education training fall 2010.

Note: Specific training logistics and registration information will be sent out prior to the trainings.

Implementation Plan and Timeline:

We will invite partners that serve WIC participants and provide nutrition education to attend a regional Group Participant Centered Education training in the fall 2010.

Activity 2: Each agency will invite community partners that provide breastfeeding education to WIC participants to attend a Breastfeeding Basics training and/or complete the online Oregon WIC Breastfeeding Module.

Note: Specific Breastfeeding Basics training logistics and registration information will be sent out prior to the trainings. Information about accessing the online Breastfeeding Module will be sent out as soon as it is available.

Implementation Plan and Timeline:

We will invite community partners that provide breastfeeding education to WIC participants to attend a Breastfeeding Basics training and/or complete the online Oregon WIC Breastfeeding Module.

Goal 4: **Oregon WIC staff will increase their understanding of the factors influencing health outcomes in order to provide quality nutrition education.**

Year 1 Objective: **During planning period, each agency will increase staff understanding of the factors influencing health outcomes.**

Activity 1: Local agency staff will complete the new online Child Nutrition Module by March 31, 2011.

Implementation Plan and Timeline:

We will complete the new online Child Nutrition Module by March 31, 2011.

Activity 2: Identify your agency training supervisor(s) and projected staff quarterly in-service training dates and topics for FY 2010-2011. Complete and return Attachment A by May 1, 2010.

Agency Training Supervisor(s):

Sue Schiess, R.D.

EVALUATION OF WIC NUTRITION EDUCATION PLAN FY 2009-2010

WIC Agency:_____Klamath County WIC_____

Person Completing Form:_____Susan M. Schiess_____

Date:_03/29/2010_____ Phone:____541-883-4276_____

Return this form, attached to email to: sara.e.sloan@state.or.us by May 1, 2010

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

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

Year 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 module by December 31, 2009.

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

- Did staff complete the module by December 31, 2009?
- Were completion dates entered into TWIST?

Response:
We completed the Food Package Assignment Module as a group in July 2009.

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.

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

- How were staff who did not attend the 2009 WIC Statewide Meeting trained on the topic of infant feeding cues?
- How has your agency incorporated the infant cues information into 'front desk', one-on-one, and/or group interactions with participants?

Response:
All of staff attended the training session at the statewide meeting, except one staff member, Linda Frei. Linda then completed the training by watching the instructional video.

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.

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

- Were nutrition education lesson plans and written materials reviewed and revised?
- What changes, if any, were made?

Lesson plans and written materials were reviewed. Lesson plans and materials were found to be consistent with the Key Nutrition Messages and new WIC food packages.

Activity 4: Identify your agency training supervisor(s) and staff in-service dates and topics for FY 2009-2010.

Evaluation criteria: Please use the table below to address the following question in your response.

- How did your staff in-services address the core areas of the CPA Competency Model (Policy 660, Appendix A)?
- What was the desired outcome of each in-service?

FY 2009-2010 WIC Staff In-services

In-Service Topic and Method of Training	Core Competencies Addressed	Desired Outcome
Example: Providing Advice Facilitated discussion during October 2009 staff meeting using the Continuing Education materials from Oregon WIC Listens.	**Example:** This in-service addressed several competencies in the core areas of Communication, Critical Thinking and Nutrition Education	**Example:** One desired outcome of this in-service is for staff to feel more comfortable asking permission before giving advice. Another desired outcome is for staff to use the Explore/Offer/Explore technique more consistently.
Food Package Module Inservice 07/09 Staff worked through the Food Package Module together.	Core areas addressed: Communication, Critical Thinking, Nutrition Education, Multicultural awareness	So that staff are prepared and comfortable for the upcoming changes to the WIC food package in August 09.
Oregon WIC Listens – Summary and overview with our WIC Listens Trainer- 10/09	Core areas addressed: Communication, Multicultural awareness, Critical Thinking, Nutrition Education	Reviewed what we had learned during the WIC Listens training process, identified Sowing, Growing and Glowing skills
WIC Link – Review of food packages for WP to WE and food packages for BF Twins	Core areas address: Critical Thinking – assigns the food package most appropriate to the participants category, risk and personal preferences	Review of the WIC Link information regarding these food packages to assure clients are getting the appropriate foods.
Civil Rights Training – 03/10	Core area - Multicultural Awareness	To be sure everyone is up to date and trained properly on Civil Rights

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

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

Activity1: 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.

Evaluation criteria: Please address the following questions in your response:

- Which core components of participant centered services are used most consistently with your staff? What has made those the most easiest to adopt?
- Which core components have the least buy-in? What are the factors that make these components difficult to adopt?

Response:
This was completed at our Oregon WIC Listens regional training in October 2009. We identified which skills were sowing, growing and glowing. In general we are glowing in: Opening the conversation, Asking permission, Affirmations. Growing in: Completing the assessment before counseling, Open-ended questions, Reflections, Summarizing, Focusing on participant's interests, Explore, Closing. Sowing in : Talk less, Listen more.

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.

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

- What strategy has been implemented to maintain the core components of participant centered services during a time of change?
- What strategy has been implemented to advance staff skills with participant centered services?

Response:
Each month we chose a different topic for all staff to focus on related to PCE. For example: November – Risk Summary Statements, December – Talking Less, Listening More, January – What is the client's interest? February – Explore, March – Setting the goal.

We also held "debriefings" on a regular basis with staff discussing how things went with clients when trying different PCE strategies.

Goal 3: Improve the health outcomes of WIC clients and WIC 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.

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

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

- Which community partners did your agency select?
- Which strategies did you use to promote the positive changes with Fresh Choices?
- What went well and what would you do differently?

Response: Our agency selected physicians and other medical office staff to promote the changes with Fresh Choices. We contacted medical offices by phone and then worked closely with them in the first weeks post food package changes. We also sent physicians and other community partners calendars in December and letters thanking them for working with us on these changes. We called our vendors to be sure they had received the training boxes and that staff was trained. There was also information in the newspaper which was outreach to the whole community.

The transition went mostly smoothly, although there have been continuing challenges around the medical documentation forms and the new standards there. There were challenges initially with some of the vendors, but that went fairly smoothly as well.

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

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

- How did your agency collaborate with the state WIC Research Analysts in evaluating Fresh Choices?
- How were you able to utilize, if appropriate, information collected from your agency?

Response:

We collaborated with analysts as requested. The information collected was very useful and enlightening and we reviewed as a group.

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

Year 3 Objective: During plan 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.

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

- What strengths and weaknesses were identified from your assessment?
- What strategies were identified to improve the support for breastfeeding exclusivity and duration in your agency?

Response:

We identified that we have strengths in many areas including: BF Mother Friendly Employer designation, Oregon WIC Listens skills, Two staff members who have completed the advanced breastfeeding training, All staff supportive of breastfeeding, breastfeeding class, breastfeeding support, breastpump distribution and education, working cooperatively with the community regarding breastfeeding, in particular working the IBCLC at the hospital.
Areas needing improvement: Breastfeeding promotion knowledge, skills and attitudes are currently not part of position descriptions and employee evaluation; Our agency does not have an IBCLC on staff; Staff members do not contact each BF mother within 1-2 wks of expected delivery; Our agency does not currently promote BF through local media.

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

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

- Which strategy or strategies did your agency implement to improve breastfeeding exclusivity and duration?
- Based on what you saw, what might be a next step to further the progress?

Response:

We chose to implement a change in job descriptions to include breastfeeding promotion knowledge, skills and attitudes. This will also be part of the employee evaluation process. Job descriptions are currently being revised and this will be complete by April 30, 2010.

Attachment A
FY 2010-2011 WIC Nutrition Education Plan
WIC Staff Training Plan – 7/1/2010 through 6/30/2011

Agency:
Training Supervisor(s) and Credentials:

Staff Development Planned

Based on planned program initiatives, your program goals, or identified staff needs, what quarterly in-services and or continuing education are planned for existing staff? List the in-services and an objective for quarterly in-services that you plan for July 1, 2010 – June 30, 2011. State provided in-services, trainings and meetings can be included as appropriate.

Quarter	Month	In-Service Topic	In-Service Objective
1	July	Preparing for World Breastfeeding Week	Planning, goals and preparation for activities during World BF Week
2	October	Group Participant Centered Education	Gaining skills to incorporate more PCE into group classes.
3	January	Online Child Nutrition Module	Staff will work through module individually and then we will discuss overview and do post-test together
4	April	Hot nutrition topics	Staff will be kept up to date on the hot nutrition topics of the day

Local Health Department: Klamath County
Plan A – Chosen Focus Area: Increase the Official Health Department Clinic Rate
March 2008-April 2011

Year 1: March 2008-April 2009				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results1**	**Progress Notes2**
A) Increase the *Official Health Department Clinic Rate** for the Klamath County Health Department (KCHD) by 6% over three years. The 2007 rate was 78%. * The *Official Health Department Clinic Rate* is defined as the number of 24-35 month olds fully covered with the 4:3:1:3:3:1 series on December first of each year. The *Rate* is published each March by OIP in the Annual Assessment of Immunization Practices.	**A1)** Expand the current recall and reminder system to include all clients beginning at 20 months of age and continuing until the December 1st after their 2nd birthday at which time they are no longer included in the *Official Health Department Clinic Rate*. **A2)** Work with the Oregon Immunization Program to obtain an accurate list of all children included in the *2008 Official Health Department Clinic Rate*. KCHD will review the list in detail and correct any inaccuracies before the *Rate* is published.	**A)** The *2008 Official Health Department Clinic Rate* provided by OIP will increase by 2% over the *2007 Rate*.	**A)** The *2008 Official Health Department Clinic Rate* provided by OIP decreased 10% below the *2007 Rate*.	**A)** The **Methods / Tasks** were implemented as planned, however immunization decreased instead of increased.

B) Increase immunization rates* for 2-year-old WIC participants by 4% over three years. The 2005 rate was 71.1%. * Up-to-date rate for 4:3:1:3:3:1 series for children age two residing in our county and registered with WIC.	**B1)** Ask OIP for a current 2007 rate for use as baseline. **B2)** Ask for support and participation from KCHD Director. Open dialog with WIC Management and employees. **B3)** Create office protocol on how to receive WIC clients. Policy will take into account differences in office hours between WIC and KCHD and standardize the flow between the two offices.	**B1)** No increase in rates is expected the first year. An ongoing dialog with WIC staff will be considered a positive outcome the first year. **B2)** Any vouchers collected will be counted and documented as a year 1 baseline. **B3)** Patient flow protocol; will be adopted and put into practice by KCHD and WIC.	**B1)** No increase in rates is expected the first year.	**B)** We have reached agreement with WIC and HD Management to increase immunization assessments during WIC visits and to facilitate referrals of clients from WIC to H.D. Clinic for immunizations. We are currently working on a protocol, a voucher system, and on solving a technical problem that is hindering progress.

[1] **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
[2] **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

Year 2: March 2009 – April 2010				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results[3]**	**Progress Notes[4]**
A) Increase the *Official*	**A1)** Reevaluate	**A)** The *2009 Official Health*	**A)** The *2009 Official*	**A1) and A2)** The

Health Department Clinic Rate for the Klamath County Health Department (KCHD) by 6% over three years.	effectiveness of current Methods and Tasks. **A2)** Continue Methods and Tasks that seem to be working. **A3)** Adjust or replace those Methods and Tasks that do not seem to be working.	*Department Clinic Rate* will increase by 2% over the *2008 Rate.*	*Health Department Clinic Rate* provided by OIP increased 1% above the *2008 rate* but remains 9% below the *2007 Rate.*	**Methods / Tasks** were continues as planned, but with only modest effect.
B) Increase immunization rates for 2-year-old WIC participants by 4% over three years.	**B1)** In addition to counting Dtap's, WIC personnel will be downloading and distributing ALERT records to parent of each client as part of their immunization screening and referral process. **B2)** WIC staff will refer client to KCHD immunization clinic using voucher system or client's PCP as indicated by ALERT forecast. **B3)** Patient flow protocol will be reviewed with WIC and	**B)** Immunization rates for 2-year-old WIC participants will increase by 2% over the previous year. **B2)** WIC vouchers will be collected and counted to determine an increase in referrals directly to KCHD.	2009 immunization rates for 2-year-old WIC participants are not yet available. The 2008 rate was 78.2%.	**B1)** WIC personnel are downloading and distributing ALERT records to each client as part of their immunization screening and referral process. **B2)** A voucher system was implemented, and clients referred to KCHD for vaccination on a one-month trial basis. Only four referrals were made to KCHD and only one child actually vaccinated. **B3)** The voucher system was abandoned as

	KCHD staff and changed as needed.			cumbersome and ineffective, but WIC continues to distribute the complete ALERT record and encourage vaccination.

[3] **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
[4] **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

Year 3: March 2010 – April 2011				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results[5]**	**Progress Notes[6]**
A) Increase the *Official Health Department Clinic Rate* for the Klamath County Health Department (KCHD) by 6% over three years.	**A1)** Reevaluate effectiveness of current Methods and Tasks. **A2)** Continue Methods and Tasks that seem to be working. **A3)** Adjust or replace those Methods and Tasks that do not seem to be working.	**A)** The *2010 Official Health Department Clinic Rate* will increase by 2% over the *2009 Rate.*		
B) Increase immunization rates for 2-year-old WIC participants by 4% over	**A1)** Reevaluate effectiveness of current Methods and Tasks.	**B)** Immunization rates for 2-year-old WIC participants will increase by 2% over the		

three years.	**A2)** Continue Methods and Tasks that seem to be working. **A3)** Adjust or replace those Methods and Tasks that do not seem to be working.	previous year. **B2)** WIC vouchers will be collected and counted to determine an increase in referrals directly to KCHD.		

[5] **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
[6] **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

Local Health Department: Klamath County
Plan B – Chosen Focus Area: Increase Promotion of the ALERT Immunization Registry
March 2008-April 2011

Year 1: March 2008-April 2009				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results[7]**	**Progress Notes[8]**
A) Transition from our current ALERT reporting system (CMHC) to IRIS (or the replacement registry when IRIS and ALERT are replaced).	**A1)** Create agreement with KCHD Management to transition to IRIS. **A2)** Identify key personnel and obtain the training they need to report immunizations to IRIS. Amanda Timmons has indicated she can provide the training here in Klamath Falls.	**A)** Be reporting the majority of vaccines we give to IRIS by March, 2009.	**A)** We are reporting the majority of vaccines we give to IRIS as of March, 2009.	**A)** The transition to IRIS has been accomplished.

	A3) Obtain the necessary software, hardware, security clearance, etc. for key personnel to access and report to the IRIS system. **A4)** Begin reporting to IRIS.			
B) Monitor data quality using IRIS reporting functions.	**B1)** Ask OIP for a current 2007 rate for use as baseline. **B2)** Improve timeliness of data reporting to IRIS.	**B)** Rate will increase to 90% timely data entry as measured by OIP by December 31, 2008.		

[7] **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
[8] **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

Year 2: March 2009-April 2010				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results[9]**	**Progress Notes[10]**
A) Transition from our current ALERT reporting system (CMHC) to IRIS (or the	**A1)** Transition to the IRIS/ALERT replacement system currently scheduled to deploy in late 2009.	**A)** Be reporting the majority of vaccines we give to the IRIS/ALERT replacement system by March, 2010.		

replacement registry when IRIS and ALERT are replaced).				
B) Monitor data quality using IRIS reporting functions.	**B1)** Run "Forecast Shots Not Given" every 4 months. **B2)** Review data for patterns or things that stand out. **B3)** Train or discuss issues with staff. **B4)** If year 2 seems successful, continues into year 3.	**B)** Conduct training with staff as needed.		

9 **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
10 **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

Year 3: March 2010-April 2011				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results11**	**Progress Notes12**
A) Transition from our current ALERT reporting system	**A1)** Reevaluate effectiveness of current Methods and Tasks.	**A)** Be reporting 100% of vaccines we give to the IRIS replacement system by March,		

(CMHC) to IRIS (or the replacement registry when IRIS or ALERT are replaced).	**A2)** Continue Methods and Tasks that seem to be working. **A3)** Adjust or replace those Methods and Tasks that do not seem to be working.	2011.		
B) Monitor data quality using IRIS reporting functions.	**B)** Continue year 2 activities. Modify as needed.	**B)** Conduct training with staff as needed.		

[11] **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
[12] **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

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