

The Public Health Foundation of Columbia County Annual Plan 2011-12

Public Health Authority

Submitted June 2011

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.

Local Public Health Authority

County

Date



Table of Contents

Section 1: Executive Summary	3
Section 2: Assessment	7
Columbia County Statistical Snapshot	8
Adequacy AND Extent to which 5 basic services are provided	13
Epidemiology and control of preventable diseases and disorders	13
Parent and child health services, including family planning clinics (ORS 435.205)	13
Collection and reporting of health statistics	14
Health information and referrals	14
Environmental health services	15
Adequacy of Other Services Important to the Community	16
Medical Surge Capabilities	17
Pregnancy Outcomes and Related Issues	18
Disease prevention and health education	23
Section 3: Action Plan	26
Epidemiology and Control of Preventable Diseases	27
Descriptions of problems, goals, activities	27
Communicable disease investigation and control	30
Tuberculosis case management	31
Tobacco Prevention and Education Program	31
Plans for obesity, asthma, and diabetes management	32
Parent and child health services, with family planning clinics	32
Problems, goals, activities and evaluations OAR 333-014-0050	32
Women, Infants, and Children Plan	34
2011-12 Nutrition Education Plan	34
WIC Staff Training 2011-12	37
Evaluation of 2010-2011 WIC Nutrition Education Plan	37
Immunization Plan	42
ContraceptiveCare Annual Report and Plan	43
Plans for other MCH activities	45
Oregon MothersCare Program	46
Environmental Health	46
Description of services	46
Description of how program requirements will be met	47
Health Statistics	50
Information and referral	52
Public Health Emergency Preparedness	53
Section 4: Additional Requirements	55
Public Health Board	56
Coordination with Local Agencies	56
Organizational Chart of CHD-PHA	58
Section 5: Unmet Needs	59
Section 6: Budget	62
Section 7: Minimum Standards	64
Attachments	75

SECTION 1: EXECUTIVE SUMMARY

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

The Minimum Standards for Local Health Departments states “In the state of Oregon, responsibility for public health protection is shared between the Oregon Health Authority (OHA) Public Health Division and the local public health authorities. Local and state agencies perform different tasks. They have unique, but complimentary roles and they rely on one another to make the public health system work effectively.” The community relies upon the partnership between the state and local government as well as the partnerships with the federal level.

If there were unlimited amounts of funding, one might expect that most public health needs would be met. The State of Oregon allots only 2.5% of its OHA budget to public health functions at the state and local levels combined. The funds that reach the local level are for specific programs. In Columbia County, these dollars supplement

- (1) Federal dollars to provide home visits to high risk infants and children,
- (2) Federal dollars that help fund emergency preparedness,
- (3) Communicable disease epidemiological response,
- (4) Federal dollars that help provide prenatal care for women in need.

State general fund provides funding for school-based health centers (SBHC). The St. Helens School District and Rainier School District both have thriving SBHCs that serve students of all ages. Vernonia School District continues to partner with Public Health to incorporate a SBHC in the new school (Fall 2012).

Funding streams provided by and defined by federal and state dollars restricts most public health services delivered locally. The public health services are impacted by formulas developed at the state level by a state/local partnership (CLHO) and contracts developed by the State of Oregon. The exception to this rule is that environmental health licensing programs are operated based on local licensing fees with 15% of the collected fees being returned to the state for state program technical assistance support. ORS 431.380 states that the distribution of funds to the local public health authority is to be used for public health services.

Columbia County through The Public Health Foundation of Columbia County (PHFCC) also has private grant dollars to support special projects. The PHFCC

currently receives funding from Meyer Memorial Trust, NACCHO, the Oregon School Based Health Care Network, the Ford Family Foundation and HRSA.

The fiscal year 2011-12 proposed PHFCC budget is included in this document. The budget is for all public health programs. The budget was approved at the June 2011 meeting by the PHFCC board. The public health program budget numbers are based on actual grant award amount received from OHA-Public Health Division (OHA-PHD). ORS 431.385 states that the local annual plan shall be submitted annually to OHA-PHD, that OHA-PHD shall review and approve/disapprove the plan, and that there shall be an appeals process if the plan is disapproved.

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

- Administer and enforce the rules of the local public health authority and the public health rules and laws
- Assure activities necessary for the preservation of health or prevention of disease in the area under its jurisdiction as provided in the annual plan of the authority or district are performed. These activities shall include:
 - Epidemiology and control of preventable diseases and disorders
 - Parent and child health services, including family planning clinics (ORS 435.205)
 - Collection and reporting of health statistics
 - Health information and referral
 - Environmental health services

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

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

The document identifies two key concepts.

The first is that public health:

1. Prevents epidemics and the spread of disease
2. Protects against environmental hazards
3. Prevents injuries
4. Promotes and encourages healthy behaviors
5. Responds to disasters and communities in the recovery phase
6. Assures the quality and accessibility of health services

The second key concept is the ten essential public health services. These services are quite limited in Oregon rural counties. Lack of funds can be restrictive in

meeting public health needs. Sufficient resources to achieve these standards are necessary for compliance.

The action plans and progress reports for this year are a continuation of the comprehensive plan. The reports included in this document are updates of the comprehensive plan. The plan formats vary from program to program based on state program needs.

SECTION 2: ASSESSMENT

Columbia County Statistical Snapshot	8
Adequacy AND Extent to which 5 basic services are provided	13
Epidemiology and control of preventable diseases and disorders	13
Parent and child health services, including family planning clinics (ORS 435.205)	13
Collection and reporting of health statistics	14
Health information and referrals	14
Environmental health services	15
Adequacy of Other Services Important to the Community	16
Medical Surge Capabilities	17
Pregnancy Outcomes and Related Issues	18
Disease prevention and health education	23

COLUMBIA COUNTY STATISTICAL SNAPSHOT

Columbia County is 687 square miles of picturesque scenery. The Columbia River defines the northern and eastern borders of the county. The terrain is mountainous with winding two lane roads. Columbia County's history is agriculture and timber oriented. Most of the agricultural land has been sold to developers and no longer produces fruits and vegetables. The timber industry is also decreasing. Housing development has replaced the farms. Family wage jobs are becoming increasingly scarce. Commuting to the Portland metro area is becoming the norm. Recently, the Columbia Rider transportation system has been established to transport commuters into the metro area. Additional routes are being mapped to provide services within Columbia County.

Geography:	Northwest Oregon, 687 square miles.
Average Temperature:	January 39 ^o F July 68.4 ^o F
Annual Precipitation:	44.6"
Population:	49,351 (2010 US Census)

Columbia County still has its high-level community issue: Access to health care. Providence Health System discontinued providing health care services in Vernonia. The Vernonia Community scrambled to obtain an "Access Point" grant from HRSA. The Astoria FQHC assisted the community. There will still be a total lack of health care in the community until the new FQHC access point services are in place. That is expected to happen by Fall 2011.

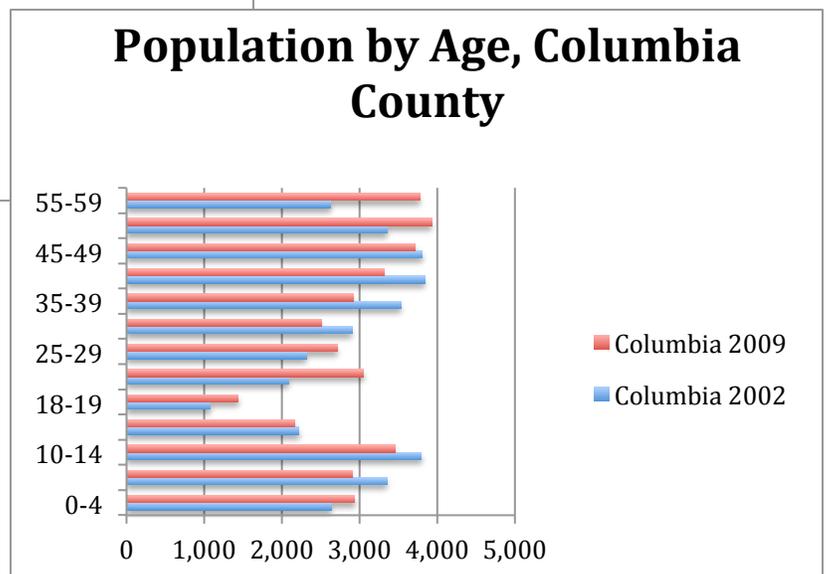
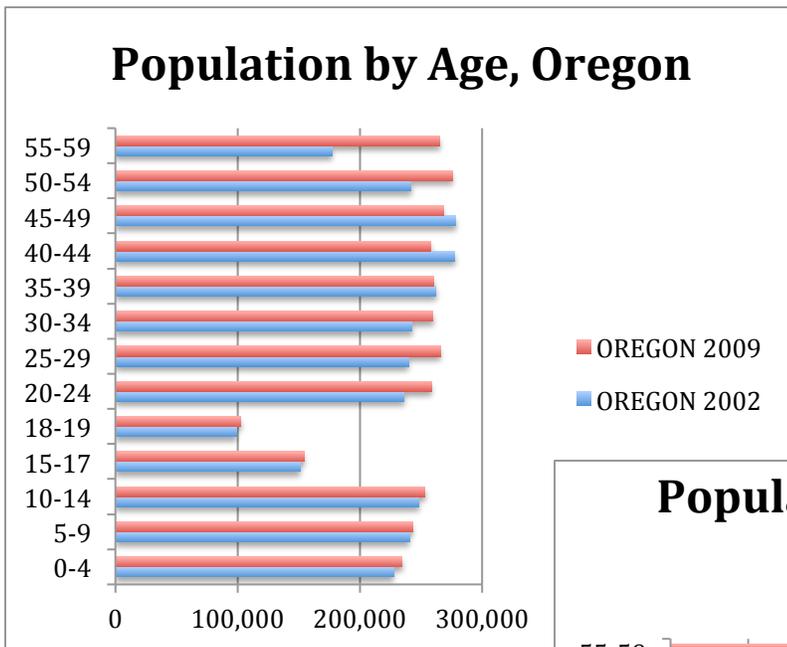
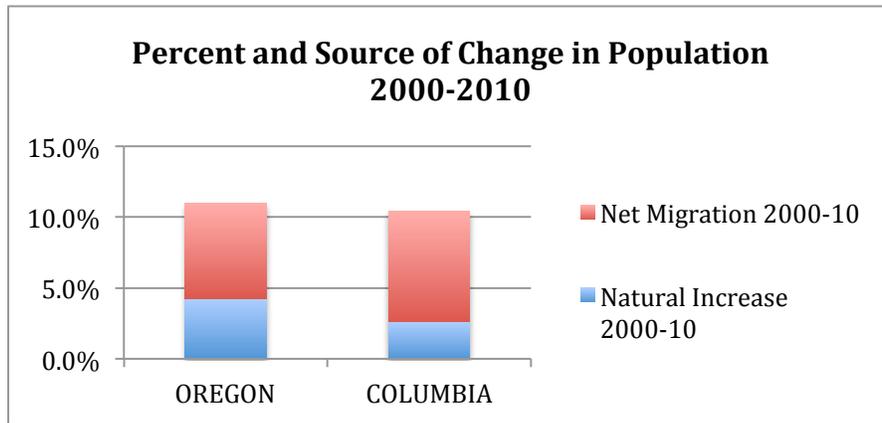
A recent survey by Medical Group Management Association shows a growing trend by hospitals to employ physicians. Hospitals have an advantage for performing out-patient procedures and provider-based billing.

The Oregon Health Authority issued two proposed denials for a 12-bed hospital in St. Helens, to the Columbia Health District. The community dynamics and tabloid-type reporting of a local newspaper turned the community against the health district. A local citizen's initiative was approved by the voters to dissolve the Columbia Health District. The CHD Board subsequently closed the hospital project, terminated the Public Health Services contract with the county and erected a resolution to have the district dissolved by the voters at the September 2011 election.

With the passage of a dissolution measure, Columbia County will have one less vehicle to help address health care access and/or recruit new providers to the area.

Of the deaths recorded for Columbia County residents in 2008, cancers and heart disease were the number one and two killers respectively. The cancer death rate was significantly higher than the state of Oregon rate with lung cancer being the most prevalent cancer.

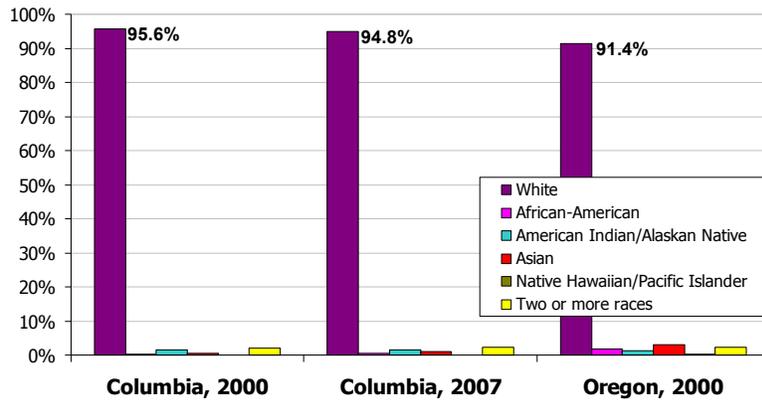
Population Research Center, College of Urban and Public Affairs, Portland State University



Population by race 2000 and 2007

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

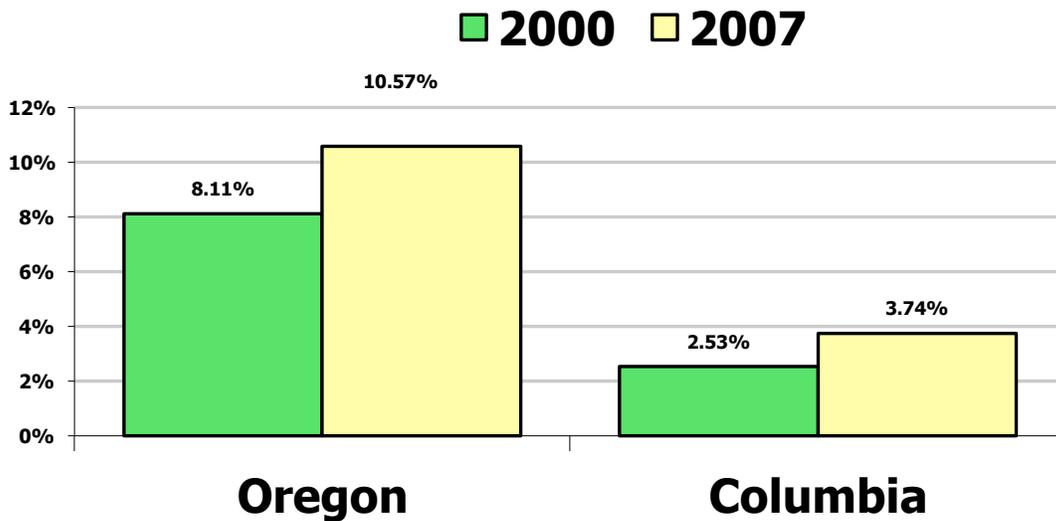
Source: US Census Bureau County Population Estimates



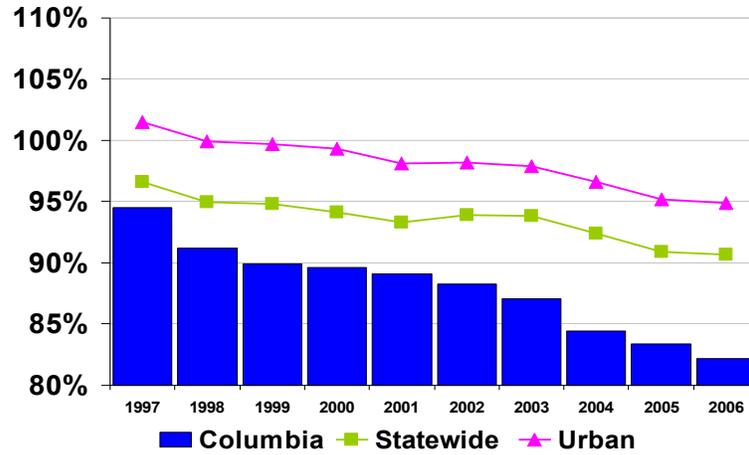
Percent that is Hispanic, 2000 and 2007

Source: US Census Bureau County Population Estimates

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

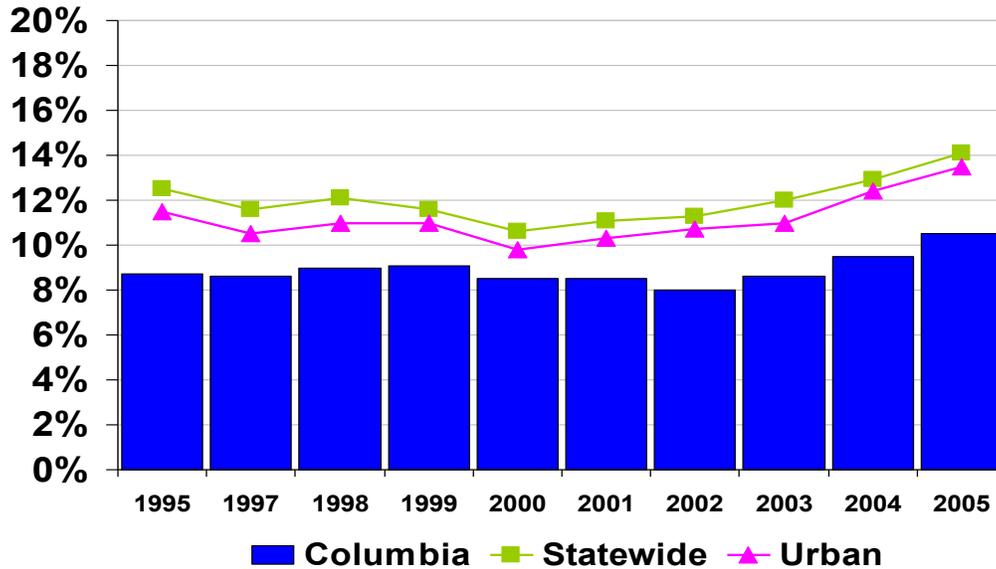


Per capita personal income as percent of the U.S. per capita income
Oregon Benchmark 11



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

Source: Current Population Survey (from US Bureau of Labor Statistics and US Census Bureau)
Oregon Benchmark 54



Number of Persons Eligible for Medicaid and Food Stamps Columbia County

State of Oregon, Division of Medical Assistance Programs | DMAP DSSURS data warehouse

Date	Number Eligible for Medicaid	Number Eligible for Food Stamps
Oct. 2002	3944	4366
Oct. 2003	3614	4839
Oct. 2004	4513	5188
Oct. 2006	4514	5404
Oct. 2007	4045	
Oct. 2008	4589	

Additional References

Child Welfare, Homelessness, Poverty, Self Sufficiency

Department of Human Services, Oregon Children, Adults and Families

http://www.oregon.gov/DHS/assistance/data/caf_charts/102008.pdf

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

Community Action Team <http://www.cat-team.org/>

ADEQUACY AND EXTENT TO WHICH 5 BASIC SERVICES ARE PROVIDED

EPIDEMIOLOGY AND CONTROL OF PREVENTABLE DISEASES AND DISORDERS

Public Health staff (public health nurses, environmental health specialists, and health officer) assess, monitor, and provide investigation of 42 diseases and nine other conditions that are considered uncommon and of potential public health significance. Laboratories licensed in the state of Oregon are required to report to counties on communicable disease results. Physicians are also required to report both labs confirmed and clinically suspect cases that are by law reportable. The public health staff investigates each report using the state's reporting guidelines, timelines, and technical assistance if needed. Disease reporting enables appropriate public health follow up for patients. Reporting helps public health identify outbreaks and provide a better understanding of morbidity patterns and may even save lives.

Public health works to identify those who have been exposed to communicable disease, provide health guidance and preventive measures, and work to prevent the spread or recurrence of disease. Public health works with the community health providers to provide education to the general public on communicable diseases.

Funding is insufficient for staff to have an active surveillance system. Columbia County is a growing community and funding has been stagnant for several years. Yet new diseases are coming to our attention every year. Two public health staff spent two weeks tracking and responding to H1N1 virus information at the national, state, regional and local level. If any other communicable disease issue had occurred during that time, we wouldn't have been able to respond adequately. We have a five-member team that responds 24/7. One member always carries the phone. They test the others on a weekly basis. The on-call person checks the fax and messages on the weekends.

PARENT AND CHILD HEALTH SERVICES, INCLUDING FAMILY PLANNING CLINICS (ORS 435.205)

Public health offers prenatal care services in conjunction with Oregon Health Sciences University School of Nursing. The nurse midwife provides prenatal care until delivery and OHSU nurse midwives deliver the baby.

Public health provides the following prenatal care services:

- Maternal case management to our clients.
- Home visits to babies who are at risk of social or medical complications or care coordination for those infants who have known medical issues.
- Contraceptive Care services to women and men.
- A range of contraceptive methods and pregnancy testing.
- Information and education on the options we provide.

Public health offers the Women, Infant, and Children (WIC) nutrition program and the farmer's market program when it is available. WIC travels to Clatskanie, Rainier, and Vernonia monthly to certify clients.

Public Health began offering Oregon MothersCare Program January 2010. The Oregon MothersCare provides prenatal needs assessment appointments at no charge. The site coordinator provides coordination with pregnancy testing, prenatal care, OHP assistance, referrals and education resources no charge.

The Public Health Foundation now has two school-based health centers in the county. St. Helens has an kindergarten through grade 12 model and the Foundation passes through dollars to the Sacagawea SBHC. Rainier has a K-12 student model and public health is the medical sponsor for this program currently. Rainier School District opened their center in June 2009. Our goal is to have a school-based health center in each school district. Columbia County has five school districts.

COLLECTION AND REPORTING OF HEALTH STATISTICS

Columbia County registers all deaths that occur in Columbia County. Since we currently do not have a hospital, only at-home births are registered at the county level. The county forwards the information to the state as required by administrative rules. The county contracts with the state for medical examiner services. The state medical examiner's office determines whether a death in Columbia County requires an autopsy.

HEALTH INFORMATION AND REFERRALS

Public Health strives to link people to needed personal health services and assures the provision of health care when otherwise unavailable. Public Health has a new website that is updated by local public health program staff. This site is easy to use and has links to many of our partners. It is an excellent way for the local level to

access the state website as well as the CDC website. Public Health also provides information and referral services during regular business hours. A local community action team agency produces a countywide resource booklet that all the local agencies use for referral.

Primary health care services are harder to provide referral for. There are no reduced fee or free clinics in Columbia County. OHSU Scappoose and Legacy St. Helens will provide services and bill clients after the service is provided. Public Health refers to Outside In in Portland and The Family Health Clinic in Longview, Washington. Because of this lack of health care services, Public Health has worked toward building a hospital and establishing school-based health centers. Public Health contracts with Oregon Health Sciences University School of Nursing for nurse practitioners to provide primary health care services and women's health care services.

Public Health assists eligible people in applying for the Oregon Health Plan. Public Health has most of their health education materials in alternative language formats, a translator service available, and provides access via a TTY number. The agency also works in collaboration with Columbia County regarding vulnerable populations during emergencies and disasters.

Public Health provides a competent public health and personal health care workforce. Life-long learning through continuing education, training, and mentoring are available to agency employees. Public Health has monthly staff meetings, an online training system, and offers continuing education activities throughout the year. Employees are encouraged to seek training opportunities connected with their positions. Most employees attend at least one outside training or conference each year. An educated and trained workforce helps public health attain its goals.

ENVIRONMENTAL HEALTH SERVICES

The environmental health program licenses and inspects restaurants, motels, RV parks, pools, spas and organizational camps. Our environmental health specialist teaches and certifies food handlers. Food handlers can take the test for a permit in the public health office during regular business hours or take the test online. A link from the Foundation website will take them to the Lane County food handler's online testing site. Public Health also licenses and inspects temporary food events that are open to the public.

Public health investigates reported cases of food-borne and water-borne illnesses. Public health staff offer education and assistance to nursing homes, assisted living facilities and other institutional settings with outbreaks.

Environmental health monitors and surveys different water systems. There are community water systems; non-transient, non-community water systems; transient non-community water systems; and state regulated water systems. The water program is a program that has struggled for years. In the 2009-10 legislative session additional dollars were provided and Public Health was able to hire a part-time environmental health specialist to monitor and follow up on significant non-compliers, to survey one-third of the water systems we need to survey and to work with systems to complete their emergency response plans. There is a possibility that these water dollars will be lost for the next biennium.

ADEQUACY OF OTHER SERVICES IMPORTANT TO THE COMMUNITY

HEALTH CARE ACCESS IN COLUMBIA COUNTY

In 2011, the governor designated Columbia County a Medically Underserved Population.

Not only is health care access limited in Columbia County, but also healthcare costs in Oregon and the U.S. have been growing at a rate higher than the rest of the market for the last decade. For clinical services provided, Public Health is able to bill Oregon Health Plan to balance a portion of the rising costs. For those who are privately insured, there is a sliding scale based on household income. Uninsured patients are assisted in applying for enrollment in the Oregon Health Plan. The Office of Health Policy and Research presented a paper to the 74th legislative assembly titled “Trends in Oregon’s Healthcare Market and the Oregon Health Plan.” The paper is summarized below, to show the impact of Oregon Health Plan trends on individuals, families, and local public health authorities.

The main drivers of healthcare costs are: growing and shifting population, age distribution, racial and ethnic makeup, and economic factors. Oregon families do not have the financial capacity to contribute significantly toward healthcare costs until they are earning at least 250% of the federal poverty level (\$51,625 for a family of four in 2007). Increasingly expensive health insurance premiums and declining employer-sponsored coverage are both likely contributors to Oregon’s uninsured population, which remained statistically flat from 2004 at 17% uninsured to 15.6% uninsured in 2006. Unemployment in Columbia County is 14% as of April 2009, and with unemployment we see rising rates of uninsured.

Of Oregon Health Plan (OHP), Medicaid and SCHIP enrollees approximately 55% are children 18 years and under, 35% adults 19-64 years of age, and 9% adults 65 years and older.

A 2004 survey of children from low-income families in Oregon found that children without a usual source of care were three times more likely to be taken to an emergency room or an urgent care clinic for regular care. The School-Based Health Center planning efforts attempt to improve children’s access to primary care, thus reducing emergency room/urgent care visits.

Oregon’s health care safety net is a community’s response to meeting the needs of people who experience barriers that prevent them from having access to appropriate, timely, affordable and continuous health services. Oregon’s healthcare safety net includes:

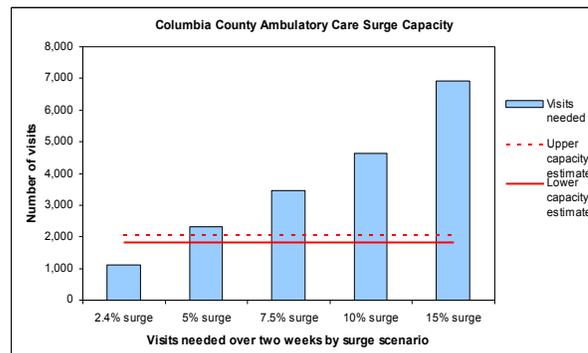
Type of Center	# In Columbia County
Federally Qualified Health Centers	0
Rural Health Centers	2
Tribal Health Centers	0
County Health Departments	1
Migrant Health Centers	0
School-Based Health Clinics (SBHC)	2
Veteran's Administration Clinics	0
Volunteer and Free Clinics	0
Hospital emergency departments	0
Some private healthcare providers	NA

Chronic disease in Oregon represents areas of opportunity for the state where improved quality and access to primary healthcare can improve health status and reduce costs associated with these conditions. Although heart disease has decreased over the last fifteen years, diabetes has increased. High-risk conditions such as high blood pressure, high cholesterol, and obesity are strongly related to many chronic conditions. Screening for these conditions can help to detect chronic disease early in its development. Decreasing prevalence of these conditions is important in reducing the chronic disease burden in the population. In 2008, Public Health was awarded competitive funding to participate in an innovative initiative to reduce chronic disease through policy, systems, and environmental change. In 2009 additional implementation funding was awarded at the state level, as well as competitive grant funds from the Centers for Disease Control and Prevention and the National Association of City and County Health Officials.

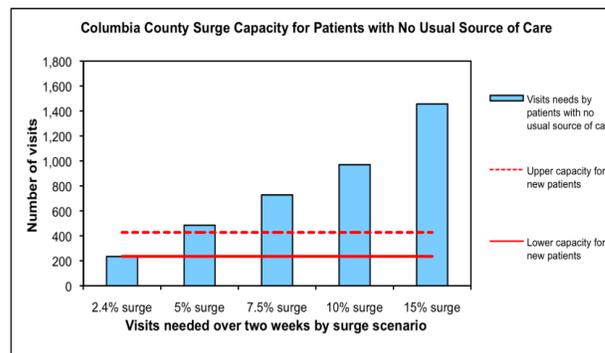
MEDICAL SURGE CAPABILITIES

Public Health Preparedness (PHP) is a public health program that networks and plans with the community medical system. The two entities support each other for the community's benefit. All medical clinics must have plans that address surge capacity as well as employer absenteeism during emergencies. Public Health has a process to request Strategic National Stockpile (SNS) supplies and the Medical Reserve Corps to assist in emergencies. The chart below shows that Columbia County would exceed a 5% capacity with less than 2000 extra visits.

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



The next chart shows that Columbia County's uninsured population would be overwhelmed at 2.4% surge (approximately 200 visits over two weeks). Columbia County clearly needs increased access to services. A hospital and more School-Based Health Centers would help with this need.



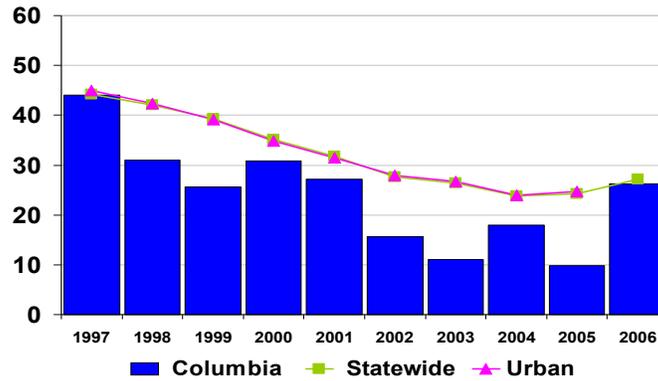
Columbia County needs improved health care access, particularly for the uninsured and low-income population.

PREGNANCY OUTCOMES AND RELATED ISSUES

Another significant health issue for Columbia County residents is women's health. CHD-PHA helps meet the health needs of women and children through multiple programs including the ContraceptiveCare program. In 2006, the

ContraceptiveCare programs were required to implement new guidance from Centers for Medicare and Medicaid Services (CMS). In order to be eligible for a subsidized visit, a client has to provide proof of United States residency (picture ID plus birth certificate).

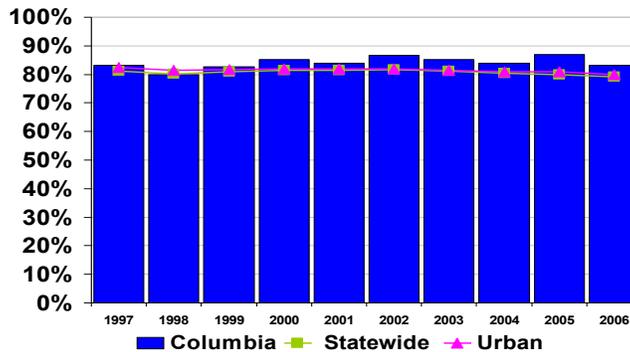
Pregnancy rate per 1,000 females ages 15-17



The number of clients receiving access to ContraceptiveCare services in our clinic declined.

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

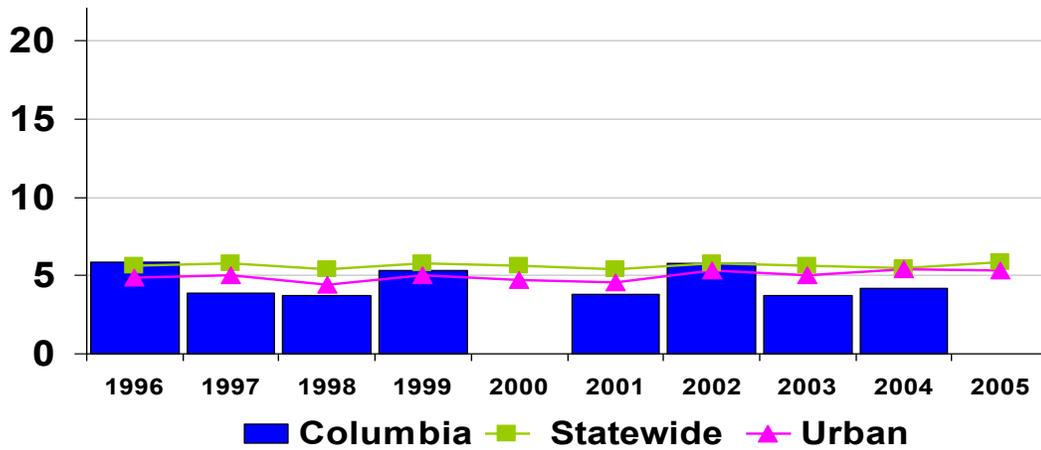
Oregon Department of Human Services, Center for Health Statistics, Oregon Vital Statistics
Annual Report Oregon Benchmark



Public Health offers prenatal care. Although access has not changed much over time, Columbia County is still slightly better than the state average, overall.

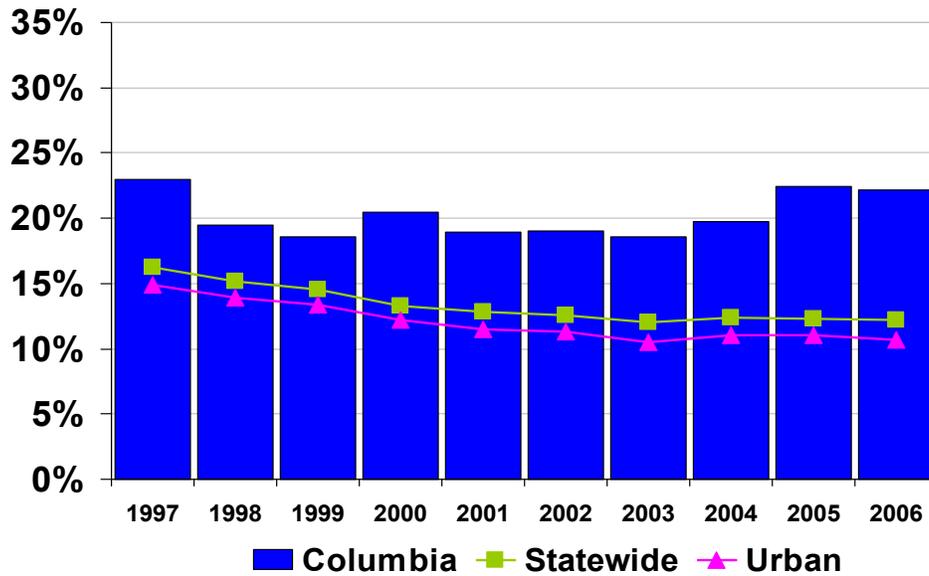
Infant mortality rate per 1000

Oregon Department of Human Services, Center for Health Statistics, Oregon Vital Statistics
Annual Report Oregon Benchmark 41



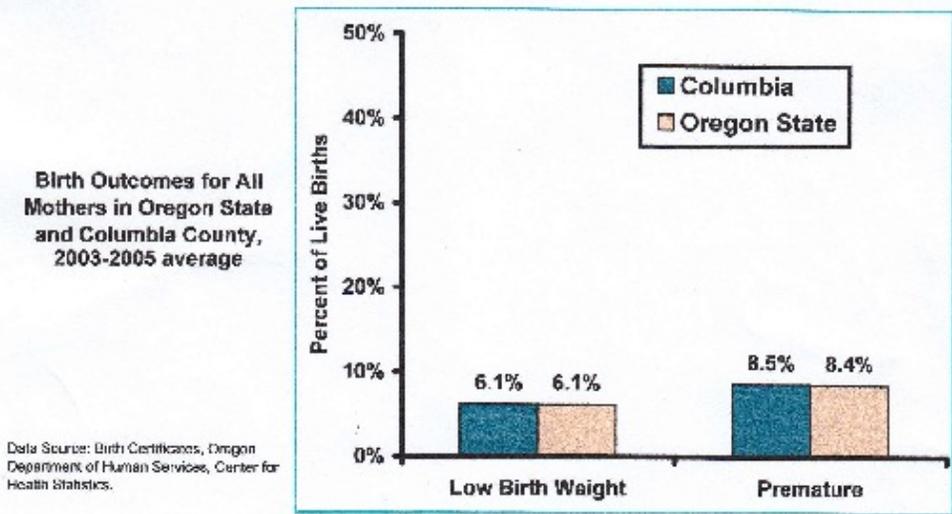
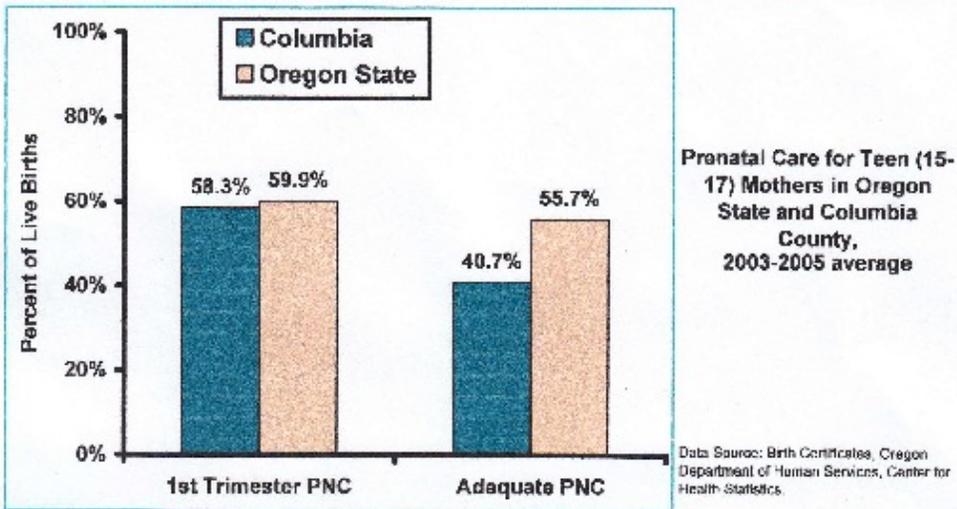
Percent of infants whose mothers used tobacco during pregnancy (self-reported)

Oregon Department of Human Services, Center for Health Statistics, Oregon Vital Statistics
Annual Report Oregon Benchmark 53b



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

**Teen Pregnancy and Birth in
Columbia County, 2005**



Prepared By: ORDHS, Office of Community Health and Health Planning (April 2007) using VistaPHw
Page 4 of 8

Pregnancy totals for all ages in Columbia County, Oregon, 2007 = 537. *Oregon Vital Statistics County Data 2007, DHS, Table 2-10.

Of this total, 4.3% received inadequate prenatal care (less than 5 prenatal visits or care began in the 3rd trimester). This is significantly lower than the State average

of 6.4%. Columbia County ranked in the top 10 for clients who received adequate prenatal care. **Oregon Vital Statistics County Data 2007, DHS, Table 2-20.*

In 2007, 84.1% of the 537 pregnant women in Columbia County, received prenatal care in the 1st trimester, this is significantly higher than the State average of 78.4%. **Oregon Vital Statistics County Data 2007, Table 2-20.*

Of the 537 total live births, 23 infants were born with low birth weight, or a low birth rate of 42.8 per 1000 births, compared to the State average low birth rate of 61.0 per 1000 births. **Oregon Vital Statistics County Data 2007, DHS, Table 2-32.*

Based on the Perinatal Data provided by DHS, Public Health provided prenatal care to 109 unduplicated women from July 2006 to June 2007:

- 89 were unplanned
- 89 had nutritional risk factors
- 35 had tobacco use
- 13 had substance abuse issues
- 4 noted domestic violence
- 18 had no high school degree
- 0 were 17 years of age or under
- 4 were homeless
- 79 were unmarried

Maternal Risk Factors by County of Residence, Oregon 2007 shows Tobacco use in the 537 pregnant women in Columbia County was 16.1%, our County ranks 18th in the State of Oregon, above the State average of 11.7%. **Oregon Vital Statistics County Data 2007, DHS, Table 2-15.*

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

In 2005, 29 low birth weight babies were born to Columbia County parents. This rate was lower than the previous year and lower than the state rate over a five-year period of time. Entry into prenatal care in the first trimester was 87 percent, but six percent had inadequate care, defined as less than five visits or late entry into care.

The risk factors for these women were not significantly different from the state’s overall maternal risk factors. Ninety-nine of 524 pregnant women smoked during pregnancy. This indicator is higher than the state and higher than the urban area. Smoking has a tremendous impact on both the baby and the mother’s health. That impact continues to negatively impact infants and children as they grow.

DISEASE PREVENTION AND HEALTH EDUCATION

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

Cause of Death	Public Health Foundation Program to prevent
Tobacco use or second-hand smoke	Tobacco Prevention and Education Program (TPEP)
Poor diet	Healthy Communities Women, Infants, Children (WIC)
Alcohol consumption	
Microbial agents	Communicable Disease Environmental Health Immunizations Emergency Preparedness
Toxic agents	
Motor vehicle accidents	
Firearms	
Sexual behavior	Family Planning Students Today Aren’t Ready for Sex (STARS)
Illicit drug use	

This year our county will receive a full grant for tobacco prevention dollars. Columbia County will educate and work with businesses and government around business policy. This program also works with schools and student groups. We also have two school-based health centers and private grants to continue planning for two additional health centers.

Oregon has an Indoor Clean Air Act. The counties respond to complaints and provide the footwork for the state. The state health division also has limited funds available to provide some counties with a “Healthy Communities” grant to help prevent, diagnose and manage chronic diseases in local communities. Columbia County is a recipient of one of these grants. Additional steps are being taken to implement the three-year Healthy Communities plan, comprised of objectives established by the Columbia Community Health Advisory Council.

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

The second actual cause of death in the U.S. is poor diet. Counties provide diet education to several population groups. Through WIC, counties serve pregnant and breastfeeding women, infants and children through the age of four with nutritional risks. School-based health clinics and women's health clinics assess diet and educate if the client is interested. Columbia County has two school-based health centers: one in St. Helens that serves the K- 12 grade population, and one in Rainier that serves K-12 grades. There are two other communities interested and planning for school-based health centers. The Columbia County Extension Service provides the community education programs available to the general public in our county.

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

The fourth largest actual cause of death in the U.S. is microbial agents. Public health has invested dollars that will help protect the entire population. Public Health has for 20 years offered both influenza and pneumonia vaccinations to the entire population. Currently, the state is purchasing influenza vaccines. As part of our Public Health Preparedness program, we have developed pandemic influenza mass prophylaxis plans, which are annexes to the county Emergency Operations Plan. This funding gives us the opportunity to plan for the most likely major public health problem that may occur. Planning is essential and so is practice. The agency is conducting exercises, using these vaccines and administering them to infrastructure resources in our communities and the general population. The 2009 H1N1 influenza pandemic gave us the opportunity to exercise our communication, medication distribution, education and messaging skills. Staff turnover means that plans are not necessarily followed and chaos occurs, so we continue to update and exercise our plans and employees on an annual basis.

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

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

Illicit drug use is the ninth actual cause of death in the CDC list. Our community mental health agency has the only drug treatment program with extensive

education in our county. The unmet needs are many and the dollars are finite, stretched thinner and thinner each year.

SECTION 3: ACTION PLAN

Epidemiology and Control of Preventable Diseases	27
Descriptions of problems, goals, activities	27
Communicable disease investigation and control	30
Tuberculosis case management	31
Tobacco Prevention and Education Program	31
Plans for obesity, asthma, and diabetes management	32
Parent and child health services, with family planning clinics	32
Problems, goals, activities and evaluations OAR 333-014-0050	32
Women, Infants, and Children Plan	34
2011-12 Nutrition Education Plan	34
WIC Staff Training 2011-12	37
Evaluation of 2010-2011 WIC Nutrition Education Plan	37
Immunization Plan	42
ContraceptiveCare Annual Report and Plan	43
Plans for other MCH activities	45
Oregon MothersCare Program	46
Environmental Health	46
Description of services	46
Description of how program requirements will be met	47
Health Statistics	50
Information and referral	52
Public Health Emergency Preparedness	53

EPIDEMIOLOGY AND CONTROL OF PREVENTABLE DISEASES

DESCRIPTIONS OF PROBLEMS, GOALS, ACTIVITIES

The role of public health and communicable diseases is defined in ORS 413.416 2(a) and the Oregon administrative rules 333-014-0050(2)(a). In this law it specifies the diseases of public health importance that must be reported by diagnostic laboratories and health care professionals. Local health departments are the first to investigate reports. Their role according to the 2007 Oregon Communicable Disease Summary is to collect demographic information about the case, characterize the illness, identify possible sources of the infection, and to take steps to prevent further transmission. Program elements # 01, #03 and #07 are the state contract components that allow funding of the activities and that define the requirements local counties are required to perform. Together funding, epidemiologic, and laboratory data constitute Oregon's surveillance system.

This table is a side-by-side comparison of some communicable diseases and their incidences in Columbia County in 2004, 2007, and 2008. Public Health reported communicable disease cases to the Oregon Public Health Division at a rate of 55% within 1 working day, and 45% within 2-5 days. The table shows minor changes in most of the reportable conditions listed:

Communicable disease	2004	2007	2008	2009	2010
HIV/AIDS	2	25 (prevalence)		23	27
Campylobacteriosis	9	4	8	4	13
Chlamydiosis	72	96		137	144
Cryptosporidiosis	0	1	0	8	8
E.coli 0157	1	0	1	0	0
Giardiasis	2	5	5	4	3
Gonorrhea	9	7		2	3
Haemophilus influenza	0	1	0	0	1
Hepatitis A	0	0	1	0	0
Hepatitis B (acute)	1	2	0	0	0
Hepatitis B (chronic)	1	1	2	2	7
Hepatitis C (acute)	0	0	1	0	0
Hepatitis C (chronic)	N/A	280(prevalence)		N/A	N/A
Hemolytic-uremic syndrome	0	0		N/A	N/A
Legionellosis	1	0		0	0
Leprosy	0	N/A		N/A	0
Listeriosis	0	0		0	0
Lyme Disease	0	0		0	1
Malaria	0	0		0	0
Meningococcal Disease	1	0		0	0

Communicable disease	2004	2007	2008	2009	2010
Pertussis	10	0	4	1	3
Q Fever	0	N/A		N/A	N/A
Rabies, animal	0	0		0	0
Relapsing Fever	0	N/A		N/A	N/A
Salmonellosis	3	4	3	2	0
Shigellosis	4	1	0	0	0
Early Syphilis	0	0		0	0
Taeniasis	N/A	N/A	N/A	0	0
Tuberculosis	0	0		1	0
Tularemia	0	N/A		N/A	N/A
Vibrio parahaemolyticus	0	N/A	1	N/A	N/A
West Nile	0	0		0	0
Yersiniosis	1	N/A	1	N/A	N/A

Chlamydiosis has continuously increased since 2004. It has also increased continuously statewide since 1998. Hopefully, this is a result of more people receiving health care and more practitioners testing for Chlamydia. Since Chlamydia is bacterial it is easily treatable with follow through on the part of the cases and their partners.

Giardiasis has also been decreasing statewide since 1998 although not in Columbia County. This county provides many camping opportunities that include chances to drink untreated water out of rivers and streams that have been contaminated by animal excrement.

H. Influenza now can be prevented by vaccination. However, currently there is a vaccine shortage and the recommendation is to delay the last dose of the four dose vaccine series. There can also be cases of non-vaccine serotypes of H. influenza and this could be causing a new replacement disease in the 0-4 year old population and 50 year old and older population.

Hepatitis A has constantly decreased since the vaccine was licensed in 1995. Columbia County hasn't had a case of Hepatitis A disease in several years. The school immunization law now includes Hepatitis A vaccine as mandatory, so we expect even less disease. Statewide, there were only 33 cases of Hepatitis A disease in 2007.

The Hepatitis B vaccine has also caused the same impact on disease statistics. Hepatitis B disease has decreased continuously statewide since 1998. The behaviors that expose a person to Hepatitis B are still prominent – unclean needle use and/or unprotected sex with a person who carries the virus.

There are more cases of chronic Hepatitis C in our county than all the other combined reportable diseases total. While we recorded no cases of acute Hepatitis C disease, we are overwhelmed with case reports for chronic Hepatitis C disease.

There is no vaccine available for Hepatitis C. The specific test that isolates Hepatitis C from other hepatitis virus is fairly new.

Meningococcal diseases have decreased statewide and in Columbia County since 1998. A vaccine exists to prevent this disease.

Columbia County in 2004 had ten cases of Pertussis. Statewide and nationally the cases of Pertussis increased until a new vaccine was introduced. The Pertussis component of the DTP vaccine was only given in children 0-6 yrs. Many of the cases of Pertussis disease were in older children and adults. A new vaccine was approved for an older population. The state has given Columbia County Tdap “special projects” vaccine to help increase the number of people protected by the new vaccine. By being immunized, this group will prevent others from acquiring the disease. In 2007, Columbia County had zero cases of Pertussis disease.

The N/A listings in the above table are due to a revision of the reportable disease statute. These diseases no longer have a separate listing, but would still be reportable under the category of “uncommon illness of potential public health significance”.

In other communicable disease activities, public health is required to investigate outbreaks. In FY 2009, CHD-PHA investigated five potential outbreaks. One outbreak was linked to norovirus. Another investigation was an active tuberculosis case that exposed a worksite. We also had the yearly experience of having a large percentage of children home ill from school and trying to determine if it was anything specific or a combination of many illnesses. Specimens were collected with some results positive for influenza A and some results positive for influenza B. There were also positive streptococcal specimens.

The program elements of PE #01 and #03 include operating a communicable disease program in accordance with the requirements and standards set forth in ORS chapters 431, 432, and 437 and OAR chapter 333, divisions 12, 17, 18, 19 and 24. The local program must investigate individual cases of specific diseases that have the potential for becoming outbreaks and actual outbreaks of communicable diseases, institute appropriate control measures and submit reports to the Oregon Public Health Division.

Program element #07 allows Columbia County to provide HIV testing and counseling. The program requires a trained counselor who can assess risk, draw venous blood samples, and counsel clients according to their risk. The program also

includes community outreach to populations that might be at risk. Columbia County uses the Partnership Project at OHSU for referrals. The Partnership Project provides an opportunity for persons living with HIV/AIDS to access medical and social services in the Portland metro area. The Partnership Project represents all of the health systems as well as government. Program element #07 has its own planning format and is not presented within this document.

COMMUNICABLE DISEASE INVESTIGATION AND CONTROL

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

The following is an action plan for one of our communicable disease program goals:

Objectives	Activities	Outcome Measures	Evaluation
Columbia County will have a CD program that follows the standards and guidelines of Oregon during the CTP timeframe	Program staff (nurse, office manager, administrator and environmental health specialist) will: <ul style="list-style-type: none"> • Monitor lab reports daily • Access OHD CD website for investigative guidelines and forms to complete on each report • Contact physician for information • Contact client for information • Give educational information to client based on individual needs • Refer client to their MD for further information and care • Offer safety net services as available through CHD-PHA (including immunizations) • Enter data into state database • Field community questions • Access state on call person with any unusual circumstances • Consult with health officer if needed 	Reports will be filed in a timely manner Disease transmission will be limited through education and referral	
CD outbreaks will be investigated in a timely manner throughout the CTP timeframe	Program staff will: <ul style="list-style-type: none"> • Call state and acquire an outbreak number • Supply test kits based on symptoms • Educate and instruct facility staff on collection and collection process • Transport specimens to OPHL for testing • Provide education on breaking chain of transmission • Provide literature to facility staff • Provide updates to the facility as results 	Limit transmission of communicable disease in group facilities Provide education to clients and facility staff	

Objectives	Activities	Outcome Measures	Evaluation
	become available <ul style="list-style-type: none"> File report with the state CD section 	Provide testing for some communicable diseases	
Education and training for program staff will be offered at least yearly	Program Staff will: <ul style="list-style-type: none"> Attend OR-EPI Complete CD 101 Complete CD 303 May attend other trainings as available and budget allows 	Program staff have completed training or are in process	
CD will have a 24/7 call system during the CTP timeframe	<ul style="list-style-type: none"> A 5 member team exists to provide on-call coverage for CD et. al. Each member has call once every 5 weeks On-call member must test other members once each week with calls or e-mails Response times will be less than an hour for this team 	The on-call team files a call out test roster response sheet each week If test is via HAN, HAN will use the member profiles	

TUBERCULOSIS CASE MANAGEMENT

Program element #03 defines the local responsibility and minimum services required for a tuberculosis program. Columbia County received \$226 for this service in FY 2009. This hardly covers the cost of one investigation. Yet, the requirements include testing, reading the results (48-72 hrs. later), follow up referrals for more specific testing, working with the health care community to assure treatment of any person testing positive and tracking down others that might have been exposed. The standard of care for treatment is observing the client taking the medicine daily or however often the medication is given. TB is increasing in the world and the U.S. due to a standard that cannot be financed. In addition, TB is increasing and becoming resistant to many of the standard treatment drugs due to noncompliance.

TOBACCO PREVENTION AND EDUCATION PROGRAM

Columbia County conducts Tobacco Prevention and Education Program (TPEP) activities. As described in Section I, part 3, TPEP attempts to tackle the number one cause of death, according to the CDC. Attachment 1 has the TPEP Action Plan for the 2011-12 fiscal year, as presented to the state DHS office (contact below).

Tobacco Prevention Education Program:

Jacqueline Villnave, MPH
 Community Programs Liaison
 Diabetes Program Coordinator
 Health Promotion and Chronic Disease Prevention Program

Oregon Public Health Services, DHS
800 NE Oregon St., Suite 730
Portland OR 97232-2162
Phone 971-673-1039

PLANS FOR OBESITY, ASTHMA, AND DIABETES MANAGEMENT

Attachment 2 has the Healthy Communities (formerly called Tobacco Related and Other Chronic Diseases TROCD) program plan. The Healthy Communities program focuses on reducing asthma, obesity, arthritis, and other chronic diseases through policy, system, and environmental change.

Healthy Communities Program:

Jacqueline Villnave, MPH
Community Programs Liaison
Diabetes Program Coordinator
Health Promotion and Chronic Disease Prevention Program
Oregon Public Health Services, DHS
800 NE Oregon St., Suite 730
Portland OR 97232-2162
Phone 971-673-1039

PARENT AND CHILD HEALTH SERVICES, WITH FAMILY PLANNING CLINICS

PROBLEMS, GOALS, ACTIVITIES AND EVALUTIONS OAR 333-014-0050

The total population of Columbia County for 2009 is 48,410. Total clients served in the contraceptive care program by this agency for FY 2010 total 802. An increase of 111 or 16.1% in clients served compared to 691 in FY 2009.

Total teen clients (male and female) served by this agency, ages 10-19 total 272, or 7.1%. Male clients as a percent of total clients for FY 2010 equal 2.7% compared to the state average of 6.6%.

Columbia County statistics showed an estimated 2,881 *Women In Need (WIN)* 2009, ages 13-44 according to the *Title X Family Planning Agency Data* information provided by DHS. Our ContraceptiveCare program served 756 unduplicated female clients, 10-44 years of age for FY 2010, or 26.2% of *Women In Need (WIN)* with the state average of 21.0%. From the *Title X Family Planning Agency Data* we also see that there were 644 *Women in need (WIN)* Teens 13-19 years of age for FY 2008. We also served 264 unduplicated female teen clients 10-19 years of age for the FY 2010, or 34% teen clients as a % of total clients, well above the State average of 26.4%.

Pregnancy Rates of Teens by County of Residence, Oregon 2007 shows teen pregnancy rate in ages 10-17 as 3.9 per 1000 women in Columbia County. This is significantly lower than the State average of 10.1%. (We are the 3rd lowest in the State!). **Oregon Vital Statistics Annual Report 2007, DHS, Table 10.1.* This is a reduction from the Oregon 2006 data, which showed the teen pregnancy rate ages 10–17 as 11.2 per 1000 women. Our Teen pregnancy rate for 10-17 year old women CY'04 = 6.6 – 5 year average = 7.4 (State rate CY'04=9.5). Our Rolling Rate from 10/04-0/05 = 4.0, well below the State Rolling Rate = 9.5. **Data supplied by Cheryl Connell at 11/06 Data Review.*

Our moving total, rolling rate and 2007 YTD Preliminary Rolling Rate (Jan. '07 to Dec. '07) = 3.6, the 3rd lowest in the State! And well below the State Rolling Rate=8.8 for 2007. ** Teen Pregnancy Chart, DHS.* Many teens in Columbia County are unemployed, or working at minimum wage jobs. The U.S. Census 2000 Quick facts shows the percent of High School graduates in Columbia County aged 25+ as 85.6%, and those with a Bachelor's degree or higher as 14.0%. The Median household income in Columbia County for 2007 = \$53,657. **U.S. Census Bureau State & County Quick Facts.* Postponing parenthood will allow these young adults more time to improve their wages and continue education and employment possibilities. The ContraceptiveCare Program – FY 2010 Data Review provided from DHS reports that our agency averted 55 teen pregnancies (under 20 years of age) and 78 Adult pregnancies (20+ years old).

Estimated tax payer savings in prenatal, labor and delivery, and infant health care costs for every unintended birth prevented by the Oregon Reproductive Health Program is about \$9,450. **Columbia County ContraceptiveCare Facts 2010. Office of Family Health, Public Health Division, Oregon Health Authority.*

Columbia County is a rural community with an estimated population of 48,410 people in 2009. **U.S. Census Bureau State & County Quick Facts.* Columbia County has over 500 births a year, but no hospital where women can deliver their babies. They must travel to Washington state or to Portland to a hospital or deliver their babies at home. Women have access to three nurse midwives and one family practice physician countywide for prenatal care. Most women travel to Portland for prenatal care. High-risk pregnant women are referred to Portland for their care. There are no local doctors who manage high-risk pregnancies. There is currently limited public transportation system, and our clients must travel by their own transportation, walk, use bicycles, or pay for a Taxi/Columbia County Rider transit service.

Our clinic hours of operation remain limited due to funding and space availability. As funds become available we hope to increase staffing, and clinic hours of operation. We continue to take great pride in providing quality confidential reproductive health care education and information to men, women and teens seeking services.

WOMEN, INFANTS, AND CHILDREN PLAN

2011-12 NUTRITION EDUCATION PLAN

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

Year 2 Objective: During planning period, staff will incorporate participant centered education skills and strategies into group settings..

Activity 1: Local agency staff will attend a regional Group Participant Centered training focusing on content design to be held in the fall of 2011.

Implementation Plan and Timeline: In order to continue the development of quality participant centered services, all Columbia County WIC staff will attend a state-sponsored regional Group Participant Centered training focused on content design. This training will occur in the fall of 2011. This activity will be completed by December 31, 2011.

Activity 2: Each agency will modify at least one nutrition education group lesson plan from each category of core classes and at least one local agency staff in-service to include PCE skills and strategies by March 31, 2012. Specific PCE skills and strategies were presented during the PCE Groups trainings held Fall 2010 and Spring 2011.

Implementation Plan and Timeline: All nutrition education group lesson plans will be built around the Explore-Offer-Explore strategy that was presented at the spring PCE training. Group lesson plans must also include components that address each of the four distinct learning styles. The October staff in-service will focus on the content of upcoming nutrition education group lessons as well as emphasize the use of the Explore-Offer-Explore strategy.

Both components of this activity will be accomplished by October 31, 2011.

Activity 3: Each agency will develop and implement a plan to familiarize all staff with the content and design of 2nd Nutrition Education options in order to assist participants in selecting the nutrition education experience that would best meet their needs.

Implementation Plan and Timeline including possible staff that will attend a regional training: The plan to familiarize all staff with

the content, design, and PCE modifications of 2nd nutrition education options will be completed by September 30, 2011 and be implemented at the October 2011 staff in-service.

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

Year 2 Objective: During planning period, each agency will identify strategies to enhance their breastfeeding education, promotion and support.

Activity 1: During planning period, each agency will incorporate participant centered skills and strategies into their group settings to enhance their breastfeeding education, promotion and support.

Implementation Plan and Timeline: The prenatal breastfeeding classes will structured around the Explore-Offer-Explore strategy that was presented at the spring PCE training. Classes will also be modified to include the use of appropriate prefilled circle charts. This will be implemented at the October 2100 staff in-service.

Activity 2: Each agency's Breastfeeding Coordinator will work with the agency's Training Supervisor to provide an in-service to staff incorporating participant centered skills to support breastfeeding counseling.

Implementation Plan and Timeline: The in-service outline and supporting resource materials will be developed by state WIC staff and sent to the local agency by July 1, 2011. Staff in-service to reinforce participant centered skills to support breastfeeding counseling will be completed by October, 2012.

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

Year 2 Objective: During planning period, each agency will continue to develop strategies to enhance partnerships with organizations in their community that serve WIC participants by offering opportunities to strengthen their nutrition and/or breastfeeding education.

Activity 1: Each agency will invite at least one partner that serves WIC participants and provides nutrition education to

attend a regional Group Participant Centered Education training focusing on content design to be held fall of 2011.

Implementation Plan and Timeline: The specifics regarding regional Group Participant Centered Education trainings have yet to be established by state WIC staff. When that component is in place, local partnering agency representatives will be invited to attend along with local WIC staff. Partnering agencies include Head Start, Le Leche League, pediatric and family practice providers, and other public health program workers. This will be accomplished by December 31, 2011.

Activity 2: Each agency will invite at least one community partner that provides breastfeeding education to WIC participants to attend a Breastfeeding Basics – Grow and Glow Training complete the Oregon WIC Breastfeeding Module and/or complete the new online Oregon WIC Breastfeeding Course.

Implementation Plan and Timeline: When the online breastfeeding course is available, community partners will be invited to participate in that learning opportunity.

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

Year 2 Objective: During planning period, each agency will increase staff understanding of the factors influencing health outcomes.

Activity 1: Each agency will conduct a Health Outcomes staff in-service by March 31, 2012.

Implementation Plan and Timeline: This in-service will be implemented using state-developed resources. It will be completed by January 31, 2012.

Activity 2: Local agency staff will complete the new online Postpartum Nutrition Course by March 31, 2012.

Agency Training Supervisor(s): Jana Mann, WIC Coordinator

WIC STAFF TRAINING 2011-12

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, 2011 – June 30, 2012. State provided in-services, trainings and meetings can be included as appropriate.

Quarter	Month	In-Service Topic	In-Service Objective
1	July 2011	Online Postpartum Nutrition course (staff will complete if available)	To increase understanding in order to provide high-quality nutrition education
2	October 2011	Nutrition Education	To focus on newly-included participant centered learning changes included in the nutrition education group lessons
3	January 2012	Health Outcomes	To increase understanding in order to provide high-quality nutrition education
4	April 2012	Breast Feeding Counseling	To increase understanding of factors that influence health outcomes in order to provide high-quality nutrition education

EVALUATION OF 2010-2011 WIC NUTRITION EDUCATION PLAN

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 online Participant Centered Education Module by July 31, 2010.*

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

- Did your WIC Training Supervisor complete the module by December July 31, 2010?

- Was the completion date entered into TWIST?

Response: This activity was completed by the Training Supervisor on June 18, 2010 and documented in TWIST.

Activity 2: *WIC certifiers who participated in Oregon WIC Listens training 2008-2009 will pass the posttest of the Participant Centered Education e-Learning Modules by December 31, 2010.*

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

- Did all certifiers who participated in Oregon WIC Listens training 2008-2009 pass the posttest of the Participant Centered Education e-Learning Modules by December 31, 2010?

Response: All of the local staff who participated in Oregon WIC Listens training passed the posttest by the established deadline.

Activity 3: *Local agency staff will attend a regional Group Participant Centered training in the fall of 2010. The training will be especially valuable for WIC staff who lead group nutrition education activities.*

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

- Which staff from your agency attended a regional Group Participant Centered Education in the fall of 2010?
- How have those staff used the information they received at the training?

Response: All of the local agency's staff attended the fall regional Group Participant Centered Education. Staff members have consistently used those skills in certifications, classes, recent public meetings, and even in office-wide staff meetings.

Goal 2: Oregon WIC staff will improve breastfeeding support for women in the prenatal and postpartum 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 December 31, 2010.

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: Specifically identified strengths worth noting are C2 (helping women to recognize their own unique strengths which will help them breastfeed successfully) and C6 (teaching women infant behavioral cues and how these relate to breastfeeding success). Specifically identified weaknesses include lack of IBCLC on local agency staff, lack of consistent contact with newly breastfeeding mothers, and occasional lack of staff availability.

Strategies for improvement include the improvement and/or possible development of local breastfeeding policy and protocols, increased staff training, and improved staff availability through the use of technology.

Activity 2: Each local agency will implement components of the Prenatal Breastfeeding Class (currently in development by state staff) in their breastfeeding education activities by March 31, 2011.

No response needed. The Prenatal Breastfeeding Class is still in development.

Goal 3: Strengthen partnerships with organizations 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 strengthen partnerships with these organizations by offering opportunities for 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.

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

- Which community partners did your agency invite to attend the Group PCE training fall of 2010?
- How do you feel partnerships with those agencies were enhanced?
- What went well and what would you do differently?

Response: Local Head Start directors were verbally invited to attend the trainings in company with local agency staff. Unfortunately, none were able to attend due to

conflicting responsibilities. The partnerships between Head Start and the local agency continue to be both strong and beneficial. It is hoped that future invitations will be accepted.

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 WIC Breastfeeding Module.

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

- Which community partners did your agency invite to attend a Breastfeeding Basics training and/or complete the online WIC Breastfeeding Module?
- How do you feel partnerships with those agencies were enhanced?
- What went well and what would you do differently?

Respond only if you invited community partners to attend a Breastfeeding Basics training. The online WIC Breastfeeding Course is still in development.

Response: Partnering agencies have been invited to participate in the online Breastfeeding Course when it is available for use.

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 June 30, 2011.

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

- Did/will the appropriate staff complete the new online Child Nutrition Module by June 30, 2011?
- Are the completion dates entered into TWIST?

Response: Certification staff will complete the online Child Nutrition module by June 30, 2011 and it will be appropriately noted in TWIST.

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

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 2010-2011 WIC Staff In-services

In-Service Topic and Method of Training	Core Competencies Addressed	Desired Outcome
<p>July, 2010 Participant Centered Services</p> <p>Facilitated discussion during July's staff meeting reviewing the skills and knowledge acquired through Oregon WIC Listens</p>	<p>This in-service specifically addressed active listening and participant centered education during certification</p>	<p>The desired outcome of this in-service was for staff to feel more skilled with active listening and to be more comfortable in asking permission before giving general advice or specific nutrition education</p>
<p>October, 2010 Improved Breast-Feeding Support</p> <p>Facilitated discussion during October's staff meeting using the <i>Supporting Breastfeeding through Oregon WIC Listens</i> assessment tool</p>	<p>This in-service specifically addressed staff support of breastfeeding mothers</p>	<p>The desired outcome of this in-service was for staff to be aware of and be more supportive of newly breastfeeding mothers by offering consistent telephone support and staff availability</p>
<p>January, 2011 Community Partnerships</p> <p>Facilitated discussion during January's staff meeting</p>	<p>This in-service focused on the use of two different satellite locations, specifically the Vernonia Community Learning Center and the Rainier Senior Center</p>	<p>The desired outcome of this in-service was for staff to be aware of facility changes and partnership support in order to provide clients with correct information</p>
<p>April, 2011 Factors that Influence Health Outcomes</p> <p>Facilitated discussion during April's staff meeting in which staff researched the factors of their choosing that influence health outcomes</p>	<p>This in-service allowed for all staff to meaningfully contribute to their own learning and to the learning of the group as a whole</p>	<p>The desired outcome of this in-service was for all staff to become more aware of the factors that influence not only their own health, but the health of the local agency's WIC participants</p>

IMMUNIZATION PLAN

Immunizations are one of the best preventive health measures available. The schedule of childhood vaccines developed by the American Academy of Pediatrics and the Centers for Disease Control and Prevention now help to protect against fourteen diseases. If you review a disease baseline from the 20th century and compare it to prevalence of specific diseases in 2004, the decrease in cases of those specific diseases clearly shows how amazing vaccines are (Red Book: 2006 Report of the Committee of Infectious Diseases, 27th edition). Smallpox, diphtheria, polio, and congenital rubella syndrome have all been decreased by 100% with the advent of vaccines. Other childhood illnesses that can have tragic consequences, such as tetanus, measles, mumps, rubella, and H. influenza type B have also been decreased by percentages that range from 82% to 99% due to vaccines.

For 2007, Columbia County had one case of H. influenza and two cases of Hepatitis B. Oregon lists Columbia County in the middle of the range of Oregon counties for both H. influenza cases and Hepatitis B occurring from 1998 to 2007. (www.oregon.gov/DHS/ph/imm/Research/index.shtml#county)

The two-year-old up-to-date immunization rate for Columbia County in 2008 was 71%. The SDA region one rate was 73% and the Oregon local health department average was 72%. The immunizations that are included in this rate are: 4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hepatitis B, and one Varicella. In order to be up-to-date, a two-year-old has to receive all of the vaccinations listed above. This information comes from the 2008 Annual Assessment of Immunization Rates and Practices provided by the OSPH division immunization program. The goal would be to have 100% of two-year-olds up-to-date.

The Kindergarten up-to-date immunization rate from 2010 is 91.8% for Columbia County, which exceeds the state rate of 88.6%.

Vaccines have even become a method for preventing specific cancers caused by some types of the human papilloma virus. The HPV vaccine became available in Columbia County in 2007. It has the potential to decrease cancers as well as decrease pap smear abnormalities caused by this virus and therefore decrease costs of health care. Another new vaccine is herpes zoster vaccine. This vaccine helps prevent shingles in older adults. Columbia County is not yet able to offer this vaccine except by special arrangement due to its high cost.

Most of our vaccines are provided through a CDC grant and we order and receive vaccines on a monthly basis. We are obligated to pay the cost of any vaccine that is destroyed or lost by other means. We also receive a grant from the state of Oregon.

For fiscal year 2009, Columbia County received \$15,321. Program element #43 of the state contract clarifies all the requirements that the health department must meet in order to receive this grant. This grant supports one day each week for immunization activities. This day includes immunizing children, ordering vaccine, completing the monthly vaccine report to the state, completing review process forms, transferring vaccine administration data via electronic transfer, completing the immunization status report, and completing the annual progress reports, and completing the outreach and education activities. The goals and objectives selected for this program follow in Attachment 3: “Immunization Comprehensive Triennial Plan”.

CONTRACEPTIVECARE ANNUAL REPORT AND PLAN

Goal 1: To direct services to address disparities among Oregon’s high priority and underserved populations, including Hispanics, limited English proficient (LEP), Native Americans, African Americans, Asian Americans, rural communities, men, uninsured and persons with disabilities.

Year of Activity	Problem Statement	Objective(s)	Planned Activities	Evaluation	Progress (those currently in process) as of 2009
Fiscal Year 2011	Title X Family Planning Agency Data for FY 2009 showed 31.3% of female clients served received EC for future use, with the State average being 21.9%	Increase the percentage of female clients receiving EC for future use to 40%	<ul style="list-style-type: none"> • Offer plan B to all clients at each visit. • Give plan B brochures/handout to each client at every visit. • Documents client's acceptance or refusal of plan B in the chart. 	<p>Review Ahlers data at 4-month intervals to evaluate progress toward goal.</p> <p>Review charts quarterly for documentation of plan B offered.</p>	<p>Based on data supplied by the "Title X Family Planning Agency Data" we provided EC to 28.8% total female clients, above the State average of 23.8%. Our teen (<20) rate was 44% (State average was 34.4%) and Adult females (>20) was 20.6% above the State average of 19.4%. Although the total did not increase from 31.3% to 40% we remained above the State average on all of our "Proportion of visits at which female clients received EC for future use".</p>

Fiscal Year 2012	Columbia County is a rural community with limited public transportation system, many clients do not have available transportation /Commuting means and must travel by walking, bicycle, or pay for a Taxi service or pay to travel via the Columbia River Rider (bus service). 2009 FY data shows 644 women in need (WIN) 13-19years of age, proportion of WIN=26.2 %, higher than the State average which is 21.0.	<ol style="list-style-type: none"> 1. Enhance services to decrease access barriers for potential clients underserved populations, both women and men, uninsured and person with disabilities. 2. Outreach to areas outside of St. Helens to more rural areas of Columbia County to provide access to Family Planning Services (CCare program) by establishing a clinic site in Clatskanie, Oregon and SBHC. 	<p>Continue Community Outreach.</p> <p>Attend community events i.e. fairs and festivals, and provide CCare flyers and information.</p> <p>Establish CCare clinic at the Clatskanie Medical Clinic where the CNM from CHDPH will see clients for Initial/Annual/New Teen/ New Supply/ECP/Preg test/FP Problem visits: the 3rd Wednesday of every month from 11am-4pm using staff from CHDPH to travel to outer county to provide services to outreach community with limited access to services d/t transportation.</p> <p>Continue to provide services based on sliding scale income and remain low cost.</p> <p>Commitment to services to establish customer relationships</p>	Review of Client data supplied by Oregon DHS "Title X Family Planning Agency Data" of services.	
------------------	---	---	--	---	--

Goal 2: Assure continued high quality clinical family planning and related preventive health services to improve overall individual and community health.

Year of Activity	Problem Statement	Objective(s)	Planned Activities	Evaluation	Progress (those currently in process)
2010-2011	Chlamydia is leading cause of infertility in young women. CHDPH testing for women by cervical swab only at initial/Annual Exams ad problem visits.	<ul style="list-style-type: none"> • Begin offering urine or a vaginal CHL testing to all new FP clients seen for Delayed Pelvic Start, ECP, or pregnancy test appointments . 	<ul style="list-style-type: none"> • Develop simple scrip that any staff can use to inform FP clients that CHL testing will be offered/done and importance of screening with a choice of specimen collection site. • Develop simple scrip for all staff to use to let FP clients know the benefits of self-collection vaginal swab and how to collect the sample. • Post collection instruction in the clinic bathroom where clients go to collect sample, as well as posting the directions in the exam rooms. • At annual exam offer FP clients choice of vaginal swab or urine for CHL screening if pelvic exam is not indicated. 	<p>Quarterly chart reviews to assess for gaps and missing opportunities of screening target populations; use these findings for quality improvement.</p> <p>Review CHL test on IPP data for target population annually and inform staff of progress.</p>	25 Chlamydia tests have been performed by the RN on visits other than Initial and Annual Exams when the client sees the CNM. To date a total of 111 Chlamydia tests have been performed with all visits.

FY 2012	Teen pregnancy rate has increased from 3.9/1000 in FY 2008 to 5.2/1000 in FY 2009	<p>To increase the number of teens receiving a birth control method to reduce unintended pregnancies.</p> <p>To provide men, women and teens with access to comprehensive and uniform health education information consisting of Family Planning services, std education, contraceptive services and ultimately reducing the number of unintended pregnancies and Std's in our community.</p>	<p>Collaborate with SBHC in Rainier to provide CCare program information /education/ brochures. Encourage referral to either CHDPH/Clatskanie Clinic for Birth control method counseling and dispensing.</p> <p>Collaborate with district School Nurses, Women's Resource Center and other community access delivery systems and community organizations to provide information and request referrals of clients to CCare program and information for men, women and teens in need.</p> <p>Provide outreach and program information to high school teachers and counselors.</p> <p>Continue walk-in services; extreme flexibility in Family Planning schedule with willingness to see clients on a "walk-in" basis during all hours of clinic operation.</p>	<p>Ahlers data and fiscal Reports showing a Reduction in FY rate.</p> <p>Data from intake form: "Where did you hear about our services</p> <p>Data source: "Pregnancy Averted Data" supplied by local DHS office.</p>	
---------	---	---	--	---	--

PLANS FOR OTHER MCH ACTIVITIES

Public Health also coordinates the planning and implementation of new School-Based Health Centers in the county. In 2000, St. Helens School District opened Sacagawea Health Center, serving students up to 8th grade. As of 2010, Sacagawea Health Center now serves grades kindergarten through twelve. In 2009, Rainier School District opened the Rainier Health Center serving kids in grades kindergarten through high school. Vernonia School District will plan for a SBHC in 2012-13. School-Based Health Centers improve health care access on 55 campuses in Oregon. In Columbia County, where health care access is particularly limited, SBHCs have impacted many families. For additional SBHC information, please contact Rosalyn Liu.

School-Based Health Centers:

Rosalyn Liu, Systems Development Specialist
 School-Based Health Center Program
 Adolescent Health Section
 Office of Family Health
 Oregon State Public Health Division, DHS
 800 NE Oregon St, Ste 825
 Portland, OR 97232
 Phone: 971.673.0248
 Fax: 971.673.0240
 Email: rosalyn.liu@state.or.us

OREGON MOTHERSCARE PROGRAM

Early and complete prenatal care is very important for the good health of both mother and baby. In Oregon, one in five women does not receive this care as soon as they should. They should be seeing a healthcare provider within the first three months of their pregnancy, the first trimester

In 1998, private and public agencies met to find a way to make sure prenatal care would be available to *all* women in Oregon within the first trimester of their pregnancy. The result of their meetings was the creation of the Oregon MothersCare Program (OMC).

This program helps women find out about and get the services they need such as:

- Pregnancy testing
- Assistance applying for the Oregon Health Plan
- Help making their first prenatal care appointment with a doctor, nurse practitioner or midwife
- Assistance making a dental appointment
- Information about the WIC program which provides nutrition education and healthy food
- Information about Maternity Case Management services offered in their community
- Other information and services they may be eligible for

Oregon MothersCare started with five sites in January of 2000 and now has twenty-nine sites as of February of 2009. In 2008, the program helped 5,111 women get pregnancy and prenatal information, assistance and services. Eighty-three percent of those women were able to get prenatal care in their first trimester of pregnancy.

To learn more about the Oregon MothersCare program contact:

Becky Seel

Oregon Department of Human Services

Office of Family Health

Oregon MothersCare Program

rebecca.seel@state.or.us

(971) 673-1494

ENVIRONMENTAL HEALTH

DESCRIPTION OF SERVICES

The responsibilities of the state Office of Environmental Health, DHS Public Health and the counties of Oregon are to:

- Assure statewide control of environmental hazards through drinking water protection, radiation protection, environmental toxicology, epidemiology programs
- Regulate food, recreational facilities (including pools and lodging) and the “honest pint”

The local level provides services according to Oregon Revised Statutes 624.010 – 624.121 including such rules concerning construction and operation of restaurants, bed and breakfast facilities, and temporary restaurants as are reasonably necessary to protect the health of those using these facilities. The rules include:

1. Water supply adequate in quantity and safe for human consumption
2. Disposal of sewage, refuse and other wastes
3. Cleanliness and accessibility of toilets and hand washing facilities
4. Cleanliness of the premises
5. Refrigeration of perishable foods
6. Storage of food for protection against dust, dirt and contamination
7. Equipment of proper construction and cleanliness of equipment
8. Control of insects and rodents
9. Cleanliness and grooming of food workers
10. Exclusion of unauthorized persons from food preparation and storage areas
11. Review of proposed plans for construction and re-modeling of facilities subject to licensing

DESCRIPTION OF HOW PROGRAM REQUIREMENTS WILL BE MET

The triennial review in 2009 revealed that inspections made did not always detail the reference to the OAR that was applicable. A concerted effort has been made to see that follow-up inspections are made as required since the triennial review. Now, all inspections make reference to an applicable OAR as required.

The triennial review from 2006 required that a Water Emergency Response plan be adopted. That document has been assembled by Public Health staff and was approved by the state.

Columbia County has 123 restaurants. Each restaurant is inspected routinely twice/year routinely. If issues arise, follow up inspections occur. Columbia County had 240 temporary restaurants last year with 150 temporary restaurants at summer events. Columbia County has a county fair, city festivals, 13 Nights on the

River (a weekly event all summer long) in St. Helens. All events require licensing to protect the public's health by inspecting to assure standards are in place.

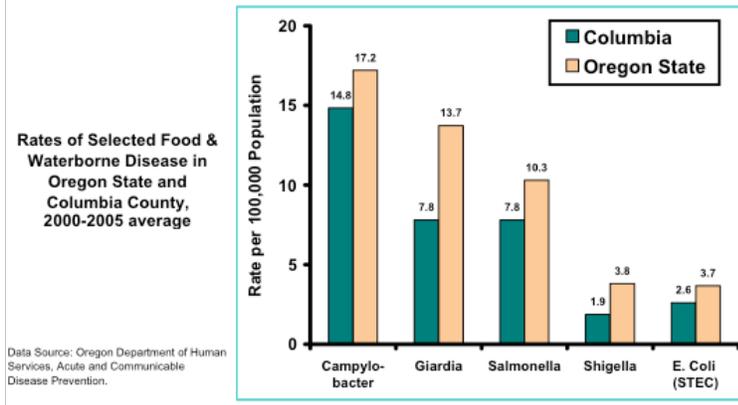
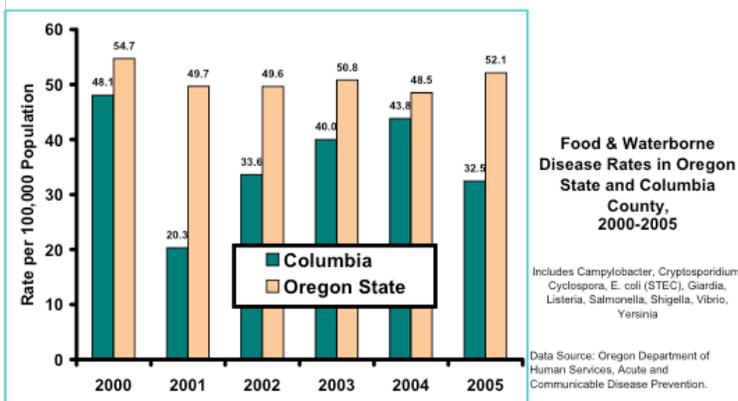
ORS 624 also requires that “any person involved in the preparation or service of food in a restaurant or food service facility licensed under ORS 624.020 or 624.320 must complete a food training program and earn a certificate of completion within thirty days after hire”. Public Health offers food handler's books and testing during regular business hours. The website also provides a link to take the food handler's test online. The online testing and permitting is offered in conjunction with Lane County.

ORS 448.005 – 448.090 regulate traveler's accommodations, recreational parks, colleges, schools, organizational camps (446.310), clubs, pools and wading pools connected to private and public businesses. Columbia County has 190 traveler's accommodations and pools. These accommodations are inspected routinely.

Water systems are regulated under ORS 448.115 – 448.285. The purpose of this statute is to ensure that all Oregonians have safe drinking water and provide a simple and effective regulatory program for the drinking water systems. The combined state/ local system is a means to improve inadequate drinking water systems. The federal safe drinking water act strives to provide good water quality with technical, financial, and educational assistance. The state/local program provides useful water quality information for the public and partners. Water quality standards provide protection to the public and preservation of the water of the state. Along with monitoring and best practices the state strives to maintain quality water standards.

The two charts below compare Columbia County and the state of Oregon on

- Food and waterborne disease rates from 2000 – 2005 and
- Rates of selected food and waterborne disease from 2000 – 2005 averages



Columbia County had lower disease rates and rates of selected food and waterborne diseases than the state for this period of time. The data source for this information is the Oregon Department of Human Services, Acute and Communicable Disease Prevention. Although Columbia County has lower rates than the state of Oregon overall, the county still struggles with those diseases. Columbia County also struggles with adequate staffing to respond to outbreaks and disease investigations. Columbia County will work on two goals for the next fiscal year.

1. Timely response to institutional outbreak settings
 - a. Epidemiological response will commence within 24 hours of notification
 - Environmental Health Specialist (EHS) or nurse will establish an outbreak investigation with the state
 - EHS or nurse will obtain forms from state and disease guidelines
 - b. Epidemiological process will be prompt and complete
 - EHS or nurse will open investigation with the facility
 - EHS or nurse will obtain sample test kits
 - EHS or nurse will transport the kits and forms to the PHL
 - EHS or nurse will review test results as they return
 - EHS and nurse will establish a plan of action for the facility
 - EHS and nurse will provide educational materials to the facility
 - Nurse will work with the facility infection control person

- EHS will inspect and work with the kitchen supervisor (if appropriate to the disease)
 - EHS will fill out state epidemiological report
 - EHS or nurse will check back with the facility in two weeks after chain of infection has been broken
- c. Evaluation will be completed by the nurse and the EHS after each outbreak
- All staff involved will meet and evaluate process
 - All suggestions for change will be given to the administrator
2. Timely response of significant noncompliers (SNCs) in small water systems to improve water quality for system users
- a. EHS will respond to SNCs within two weeks of receiving the report
- EHS will respond to individual SNCs within time frame
 - If unable to meet the time frame, the EHS will notify the administrator
 - Administrator will decide whether to add extra EHS time
- b. EHS will use process established by the state
- EHS will work with water system owner for correction or will direct an additional EHS to follow up
 - EHS will work with water system until issue is resolved
- c. EHS will evaluate process and complete report for the state
- EHS will submit report to the state
 - EHS will attend continuing education trainings on water quality
 - EHS will evaluate and assist the water system owner if additional resources are needed

HEALTH STATISTICS

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

The recent funding of the Healthy Communities program required the collection and compilation of local-level health statistics. Community resources pertaining to access to health care, fresh produce, physical activity and support groups were inventoried. Additionally, epidemiological statistics were collected from sources

such as the Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System, Oregon Healthy Teens, and many others. This inventory will be improved with the completion of a new CDC tool, called the Community Health Assessment Resource Tool (CHART).

Public Health strives to link people to needed personal health services and assures the provision of health care when otherwise unavailable. Public Health has a new website that is updated by local public health program staff. This site is easy to use and has links to many of our partners. It is an excellent way for the local level to access the state website as well as the CDC website. Public Health also provides information and referral services during regular business hours. A local community action team agency produces a countywide resource booklet that all the local agencies use for referral.

Primary health care services are harder to provide referral for. There are no reduced fee or free clinics in Columbia County. OHSU Scappoose and Legacy St. Helens will provide services and bill clients after the service is provided. Public Health refers to Outside In in Portland and The Family Health Clinic in Longview, Washington. Because of this lack of health care services, Public Health is working toward building a hospital and leading planning around the establishment of school-based health centers. Public Health contracts with Oregon Health Sciences University School of Nursing for nurse practitioners to provide primary health care services and women's health care services.

Public Health assists eligible people in applying for the Oregon Health Plan. The Foundation has most of their health education materials in alternative language formats. Public Health has access to translator services and provides access via a TTY number. Public Health works in collaboration with Columbia County regarding vulnerable populations during emergencies and disasters.

The Foundation provides a competent public health and personal health care workforce. Life-long learning through continuing education, training, and mentoring is available to Public Health employees. The agency has monthly staff meetings, an online training system, and offers continuing education activities throughout the year. Employees are encouraged to seek training opportunities connected with their positions. Most employees attend at least one outside training or conference each year. An educated and trained workforce helps public health attain its goals.

PUBLIC HEALTH EMERGENCY PREPAREDNESS

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

Disaster hit in December 2007. During the December “Flood 2007”, Vernonia, Mist, surrounding areas of Clatskanie, and portions of St. Helens were severely affected. The flood was declared a federal disaster. The medical needs were many and diverse. Most of the resources came from outside the county because an adequate infrastructure does not exist. Severe winter storms continued to adversely affect Columbia County during December 2008 and into January 2009 with heavy snowfall and flooding which caused a variety of challenges for all residents in the county including power outages and difficulty accessing critical medical services (i.e. dialysis, chemo therapy treatments). Resources from outside the county were required to address transportation needs of those citizens who required critical medical treatments. Public Health worked in conjunction with the county Emergency Management (EM) team to provide current information in January 2009 regarding ground water quality via a new web-based communication tool, WebEOC, implemented by Columbia County Emergency Management.

An epidemic of “swine flu” (aka, H1N1 influenza) was declared the end of April 2009, which evolved into a pandemic in early May 2009. During this influenza outbreak, Public Health stood up their Department Operations Center (DOC) implementing their pre-operational Incident Command Structure following the guidelines of FEMA’s Incident Command Structure. While activated, the DOC conducted disease surveillance, community mitigation to reduce disease transmission and illness severity, and provided information to the health care communities in the county as well as community partners, stakeholders, and the general public.

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

be used in exercises and emergencies and activation of the county Medical Reserve Corps for emergencies.

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

The 9-1-1 communications district has a Community Alert Network system (aka, reverse 9-1-1) that can be used by public health to notify residents of emergencies. Additionally, select populations can be singled out for notification, so people would receive only applicable information. Public health used this notification system during their full-scale flu Point of Dispensing (POD) exercises in November 2008 and 2009. The 9-1-1 system worked well to notify first responders on the day of the exercise to report for deployment to POD sites.

Since the state denied the application for a Certificate of Need for the county's hospital project, Public Health will need to increase their efforts exploring medical support options both within and outside the county. Some of this work has begun with support from the county Emergency Management and will need to continue in the upcoming year as there have been challenges with communication and willingness to participate from the existing medical service providers throughout the county. With the lack of a hospital and the limited number of medical service providers in the county, support from the Medical Reserve Corps has become more imperative. There will be increased emphasis on further training and exercising of this vital resource of licensed medical personnel for medical surge.

Through the collaborative regional work with the Portland metropolitan Cities Readiness Initiative (CRI) program we began building the Columbia County Push Partner Registry (PPR) with further growth occurring in 2009 and 2010. Columbia County will use information in the After Action Report for the 2011 CRI TOWN CRI-OR full scale exercise to further expand the county PPR and conduct future exercises for all Push Partners to participate in. This partnering with local agencies and organizations is an important aspect of Public Health's ability to ensure their ability to provide rapid dispensing of medical countermeasures to the entire county population in the event of a large scale natural or human caused emergency.

The Public Health Foundation of Columbia County continues to develop, review and revise all-hazards plans and procedures as well as ensure appropriate training opportunities are made available for Public Health staff and community partners. In addition, Public Health continues to collaborate with and explore new partnering opportunities that will allow the continuation of conducting exercises with these community agencies and response partners.

SECTION 4: ADDITIONAL REQUIREMENTS

Public Health Board

Coordination with Local Agencies

Organizational Chart of CHD-PHA

Error! Bookmark not defined.

Error! Bookmark not defined.

Error! Bookmark not defined.

PUBLIC HEALTH BOARD

The Public Health Foundation of Columbia County, through an intergovernmental agreement between Columbia County and The Foundation provides public health services and enforcement authority. The Foundation, a private non-profit with a volunteer board, provides the public health services required in ORS 431.375 - 431.385 and ORS 431.416 and rule (Chapter 333, Division 14). The Foundation board meets each month at a regularly scheduled time. The mission of The Foundation is to respond to the health needs of the citizens of the district and surrounding communities.

COORDINATION WITH LOCAL AGENCIES

The Public Health Foundation of Columbia County provides many health services to the community, as well as partnering with several local agencies. Those partnerships are described below.

Mental health services: Columbia County Mental Health provides mental health services in Columbia County. CCMH contracts with the county and is a private, non-profit agency.

Columbia County Commission on Children and Families: a department within county government. Public Health has a position on the executive board of the Commission. Public Health participates in the planning efforts of the Commission and in support of best practice program allocations.

State DHS services: State DHS staff provide self-sufficiency, food stamps, and senior and disabled services locally.

School Districts: memorandums of understanding with Rainier School District and the Sacagawea SBHC to provide school-based health center services in the two school districts.

Oregon Health Sciences University: contract for provision of women's health care through OHSU Nurse Practitioners.

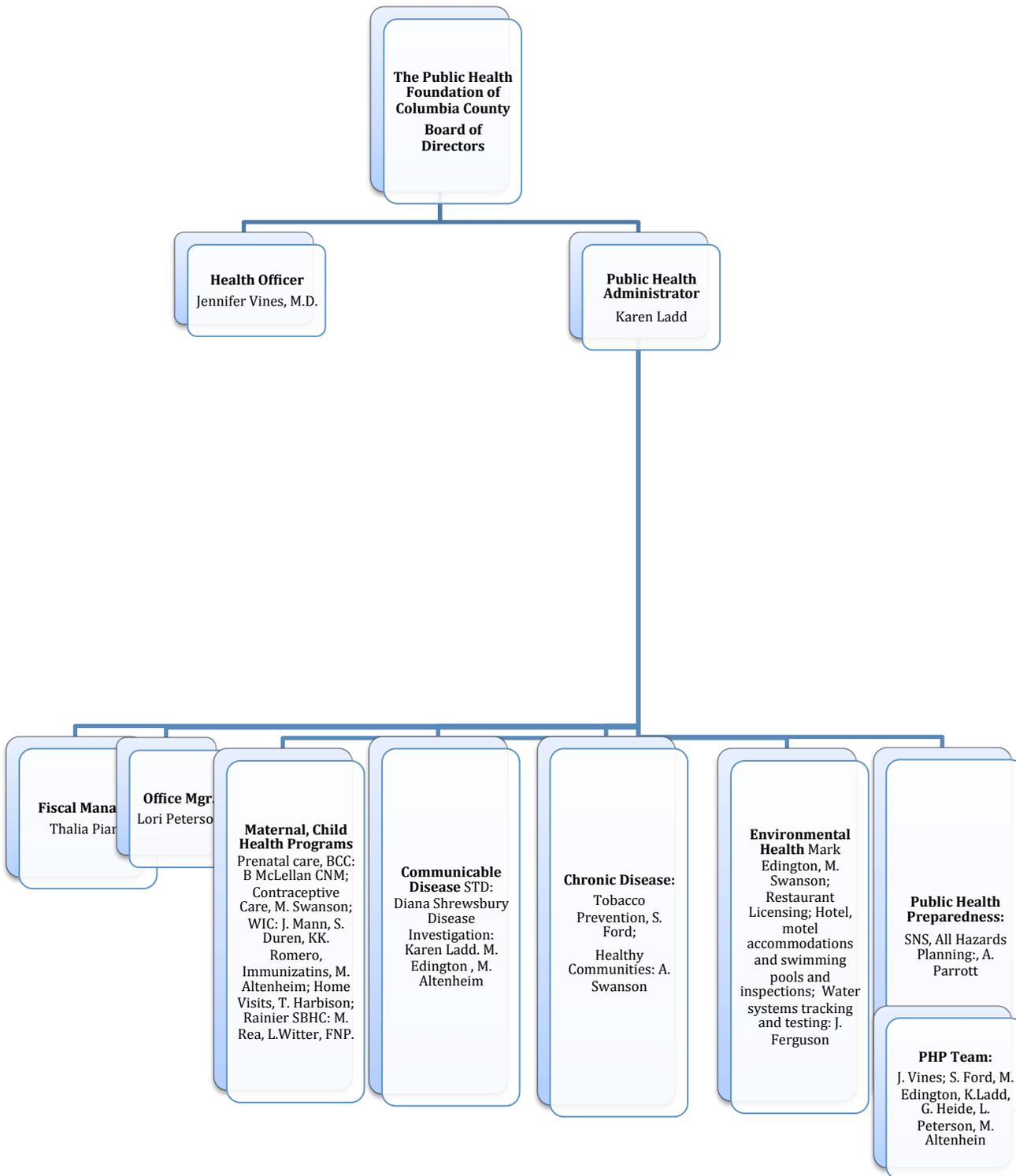
Involvement of Public Health staff in the local communities takes many forms. The public health staff participates in committees linked with their role inside the agency. The following are committees with which Foundation staff participates, locally.

- Columbia County local alcohol and drug prevention committee/Columbia County Mental Health advisory committee
- Head Start advisory committee

- Healthy Start advisory committee
- Early intervention advisory committee
- District attorney's MDT committee
- SBHC advisory committees (Rainier)
- St. Helens school-based health center advisory board (Sacagawea Health center)
- Local Commission on Children and Families
- Columbia County Emergency Planning Association
- Columbia County Medical Reserve Corps
- Homeland Security and Emergency Management Commission
- Public health foundation of Columbia County
- Teen Health Advocacy Teams (Rainier, Vernonia, St. Helens)

Regionally, staff are involved in the Northwest Region I regional coordinator and leadership emergency planning committee and the 7-county City Readiness Initiative.

ORGANIZATIONAL CHART OF CHD-PHA



SECTION 5: UNMET NEEDS

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

We lack physicians. The county needs about 19 primary care and 40 specialists. There is no hospital and no emergency room in the county and the closest ER is approximately 30 miles away. There is one urgent care clinic in the county and it does not provide services 24 hours a day. We have major unmet prevention and mental health needs, and all services in outlying rural areas are minimal. Children are particularly under served--we have a projected need for four pediatricians, yet only one currently practices in the county. In both Clatskanie and Vernonia, there is a higher death rate among young people than the rate for Oregon. We aim to expand the School-Based Health Center program thus, improving access to health care in an environment that feels safe and familiar for children.

Our population base is growing rapidly. We have a limited transportation service. Additionally many residents have low-income levels, and receive fewer services because of the lack of local health services and the challenges of transportation to outside services.

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

- Need to obtain an emergency room that operates 24 hours/day and an inpatient hospital
- Need to generate and distribute a recruitment packet for potential healthcare providers outlining advantages to practicing in Columbia County.

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

A hospital can provide an enhanced sense of medical community among providers, i.e. medical staff and medical society. It makes it easier to attract and recruit physicians and specialists. It enables opportunities for improved coordination of

existing local resources such as nursing homes, mental health, and physical therapy.

Further, it provides local infrastructure to a community:

- c. Collection and reporting of health statistics.
- d. Health information and referral services.
- e. Environmental health services.

In addition to being a medically underserved county, Columbia County is also lacking many resources for patients with chronic conditions. Below is a description of a few of the identified needs.

Columbia County has an enormous need for nutrition education for not only the diabetes population, but for our low socioeconomic population, children, organizations, and agencies. Residents do not have access to the Meals Made Easy program designed to educate and empower diabetes patients to plan meals specific to their dietary needs. In addition to Meals Made Easy there have been classes offered on food safety, food purchasing, and meal planning. Which were affiliated through the OSU Extension office. While these programs are not typically provided through public health, Public Health is currently working with the OSU Extension Service to strategize possibilities for expanding the outreach of these programs in Columbia County to meet the needs of this vulnerable population.

Additionally, Columbia County does not offer any Living Well programs for those impacted by HIV/AIDS. Living Well is designed to support, empower, and educate those impacted by chronic conditions via peer group mentorship. Public Health does provide HIV/AIDS testing and counseling. If a client is found positive Public Health refers the client to Partnership Project at OHSU for case management. However, this creates many transportation barriers for patients.

Another best-practice program that Columbia County is missing is the Arthritis Foundation Exercise Program. Although this program has not been offered in the past, we aim to address this need in the near future.

SECTION 6: BUDGET

Public Health Foundation of Columbia County

Expenditures		Fiscal Year 2011/2012	
	Description	Proposed	Approved
1	Total Salaries	830,754	830,756
2	Administrator 1.0 FTE	90,896	90,896
3	Fiscal Services 0.80 FTE	42,534	42,534
4	RNs/Medical Support	178,883	178,883
5	Sanitarian 1.2 FTE	79,042	79,042
6	Program Coordinators 4.0 FTE	196,302	196,302
7	WIC Program Support 3.4 FTE	126,004	126,004
8	Program Manager 0.5 FTE	38,740	38,741
9	Support Staff 1.7 FTE	73,553	73,553
10	On Call - Bioterrorism	4,800	4,801
11	Taxes & Benefits	190,547	190,547
12	Total Personal Services	1,021,301	1,021,303
13	Materials & Services:		
14	Building/Utilities/Maintenance	22,348	22,348
15	Phone & Communications	12,600	12,600
16	Office Supplies & Equipment	17,750	17,750
17	Postage	5,000	5,000
18	Med. Sups/Pharm./Contra.	53,700	53,700
19	Program Supplies	1,000	1,000
20	Projects & Events	4,000	4,000
21	Professional Service Agreements	14,400	14,400
22	OHSU Nurse Practitioners	47,000	47,000
23	Lab Services	7,500	7,500
24	Audit	9,300	9,300
25	Insurance & Fees	21,000	21,000
26	Bank Fees	1,200	1,200
27	Travel & Mileage	11,000	11,000
28	Cont Education (by award only)	-	-
29	Subscriptions, publications	700	700
30	Sacagawea School Clinic	36,900	36,900
31	Misc.	600	600
32	Fed HRSA Grant Expenses	485,000	485,000
33	Total Materials & Services	750,998	750,998
34	Capital Outlay	0	1
35	Contingency	100,000	100,000
36	Total Cash Expenditures	1,872,299	1,872,302
37	State Supplied Vaccine(non-cash)	35,000	35,001
38	Total Expenditures	1,907,299	1,907,303
39	Unappropriated	0	0
40	Total	1,907,299	1,907,303

Public Health Foundation of Columbia County

Resource		Fiscal Year 2011/2012	
	Description	Proposed	Approved
1	Cash Forward	157,823	157,823
2	Interest	100	100
3	State Grants:	658,485	658,485
4	State Support	55,407	55,407
5	TB Case Management	574	574
6	HIV Prevention	8,811	8,811
7	Public Health Preparedness	89,483	89,483
8	Tobacco Prevention & Education	63,346	63,346
9	Heathy Communities	48,750	48,750
10	WIC	212,063	212,063
11	Family Planning	29,429	29,429
12	Child & Adolescent Health	31,912	31,912
13	Perinatal	2,812	2,812
14	Babies First	8,900	8,900
15	Oregon Mothers Care	2,537	2,537
16	Immunizations	16,049	16,049
17	School Based Health Centers	88,412	88,412
18	OTHER GRANTS:		
19	Cacoon Grant	10,947	10,947
20	Achieve Grant	5,200	5,200
21	Federal HRSSA Grant (SBHC)	500,000	500,000
22	Meyer Memorial Trust	30,000	30,000
23	NACCHO MRC Unit Award	5,000	5,000
24	CRI Grant (Washington Co)	6,000	6,000
25	Drinking Water Systems (5533 qtr)	22,132	22,132
26	Columbia County	100,000	100,000
27	Client Fees	12,000	12,000
28	Head Start Nutritional Assessments	850	850
29	Environmental Fees	77,300	77,300
30	Oregon Contraceptive Care (FPEP)	144,000	144,000
31	OHP & other insurance	59,500	59,500
32	Water Surveys (SRF Billings)	20,000	20,000
33	Rainier Health Center Fees	8,500	8,500
34	Prenatal Expansion Project	49,937	49,937
35	Maternity Case Management	2,600	2,600
34	BCC Billings	1,700	1,700
35	Miscellaneous	100	100
36	Donations	125	125
37	Subtotal Cash Resources	1,872,299	1,872,299
38	State Supplied Vaccine (non-cash)	35,000	35,001
39	Total Resources	1,907,299	1,907,300

SECTION 7: 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 X No ___ All positions have written job descriptions, including minimum qualifications.
13. Yes X No ___ Written performance evaluations are done annually.
14. Yes X No ___ Evidence of staff development activities exists.
15. Yes X No ___ Personnel records for all terminated employees are retained consistently with State Archives rules.
16. Yes X No ___ Records include minimum information required by each program.
17. Yes X No ___ A records manual of all forms used is reviewed annually.
18. Yes X No ___ There is a written policy for maintaining confidentiality of all client records which includes guidelines for release of client information.
19. Yes X No ___ Filing and retrieval of health records follow written procedures.
20. Yes X No ___ Retention and destruction of records follow written procedures and are consistent with State Archives rules.
21. Yes X No ___ Local health department telephone numbers and facilities' addresses are publicized.
22. Yes X No ___ Health information and referral services are available during regular business hours.
23. Yes X 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 X 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 X No ___ To preserve the confidentiality and security of non-public abstracts, all vital records and all accompanying documents are maintained.
26. Yes X No ___ Certified copies of registered birth and death certificates are issued within one working day of request.

27. Yes ___ No X 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 X No ___ A system to obtain reports of deaths of public health significance is in place.
29. Yes X 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 X Health department administration and county medical examiner review collaborative efforts at least annually.
31. Yes X No ___ Staff is knowledgeable of and has participated in the development of the county's emergency plan.
32. Yes X No ___ Written policies and procedures exist to guide staff in responding to an emergency.
33. Yes X No ___ Staff participate periodically in emergency preparedness exercises and upgrade response plans accordingly.
34. Yes X No ___ Written policies and procedures exist to guide staff and volunteers in maintaining appropriate confidentiality standards.
35. Yes X 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 X 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 X No ___ There is a mechanism for reporting communicable disease cases to the health department.
38. Yes X No ___ Investigations of reportable conditions and communicable disease cases are conducted, control measures are carried out, investigation report forms are completed and submitted in the

manner and time frame specified for the particular disease in the Oregon Communicable Disease Guidelines.

39. Yes No Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or communicable disease case received.
40. Yes No Access to prevention, diagnosis, and treatment services for reportable communicable diseases is assured when relevant to protecting the health of the public.
41. Yes No There is an ongoing/demonstrated effort by the local health department to maintain and/or increase timely reporting of reportable communicable diseases and conditions.
42. Yes No There is a mechanism for reporting and following up on zoonotic diseases to the local health department.
43. Yes No A system exists for the surveillance and analysis of the incidence and prevalence of communicable diseases.
44. Yes No Annual reviews and analysis are conducted of five year averages of incidence rates reported in the Communicable Disease Statistical Summary, and evaluation of data are used for future program planning.
45. Yes No Immunizations for human target populations are available within the local health department jurisdiction.
46. Yes No Rabies immunizations for animal target populations are available within the local health department jurisdiction.

Environmental Health

47. Yes No Food service facilities are licensed and inspected as required by Chapter 333 Division 12.
48. Yes No Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.
49. Yes No Training in first aid for choking is available for food service workers.
50. Yes No Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided.

51. Yes No Each drinking water system conducts water quality monitoring and maintains testing frequencies based on the size and classification of system.
52. Yes No Each drinking water system is monitored for compliance with applicable standards based on system size, type, and epidemiological risk.
53. Yes No Compliance assistance is provided to public water systems that violate requirements.
54. Yes No All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken.
55. Yes No A written plan exists for responding to emergencies involving public water systems.
56. Yes No Information for developing a safe water supply is available to people using on-site individual wells and springs.
57. Yes No A program exists to monitor, issue permits, and inspect on-site sewage disposal systems.
58. Yes No Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.
59. Yes No School and public facilities food service operations are inspected for health and safety risks.
60. Yes No Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12.
61. Yes No A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste.
62. Yes No Indoor clean air complaints in licensed facilities are investigated.
63. Yes No Environmental contamination potentially impacting public health or the environment is investigated.
64. Yes No The health and safety of the public is being protected through hazardous incidence investigation and response.

65. Yes ___ No X Emergency environmental health and sanitation are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control.
66. Yes X No ___ All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448.

Health Education and Health Promotion

67. Yes X No ___ Culturally and linguistically appropriate health education components with appropriate materials and methods will be integrated within programs.
68. Yes X No ___ The health department provides and/or refers to community resources for health education/health promotion.
69. Yes X No ___ The health department provides leadership in developing community partnerships to provide health education and health promotion resources for the community.
70. Yes X No ___ Local health department supports healthy behaviors among employees.
71. Yes X No ___ Local health department supports continued education and training of staff to provide effective health education.
72. Yes X 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 X No ___ WIC
 - b. Yes X No ___ Family Planning
 - c. Yes X No ___ Parent and Child Health
 - d. Yes ___ No ___ Older Adult Health
 - e. Yes ___ No ___ Corrections Health
75. Yes X 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, and 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 X 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 X No ___ The local health department assures that advisory groups reflect the population to be served.
102. Yes ___ No X 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: Karen Fox Ladd

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

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

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

b. Yes 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.

ATTACHMENTS

ATTACHMENT 1: Tobacco Prevention Education Program (TPEP) Annual Plan	76
ATTACHMENT 2: Healthy Communities Annual Plan	83
ATTACHMENT 3: Immunization Comprehensive Plan	90

ATTACHMENT 1

Tobacco Prevention Education Program (TPEP) Annual Plan

Plans are created and submitted to the state DHS Office, annually.

Local Tobacco Control Advisory Group

Briefly summarize how community leaders were consulted to select the strategic direction and priorities, including those related to reducing health disparities, for the Local Program Plan for this grant application. Add rows as needed.

Community Leader, Partner, Stakeholder or other Advisor consulted	Name of Organization	Briefly describe how this Advisory Group member helped guide the development of the Local Program Plan.	If applicable, note the BPO(s) in which this individual or organization will continue to be involved.
Name of individual			
Dr. Ken Cox, Superintendent	Vernonia School District	Provides guidance to LHD in creating TF School objective and reasonable tasks/timeline. Will provide contacts for student engagement and keep Tobacco-Free policy an on-going agenda item for the Wellness Team.	BPO #8
Aaron Miller, Principal	Washington Grade School		
Nate Underwood, Principa	Vernonia Junior and Senior High		
Cici Bell, Chairperson,	Vernonia Wellness Team		
DeAnna Pearl, Director	Vernonia Prevention Coalition		
Ashley Swanson, Coordinator	Healthy Communities	Worked with HC Coordinator to identify areas for collaboration between programs.	BPO #1
Kjerstin Gould, Director	Clatskanie Together Coalition Health Coalition member	Representative from North County. Health Coalition members help set the priorities (focus on school-aged students) for TPEP workplans.	
Leeann Grasset, BS, CPS, Certified Prevention Specialist	Columbia Community Mental Health Health Coalition member	Prevention specialist, knowledgeable on best practice. Health Coalition Partner Coach (through ACHIEVE funding). Works with many of the school districts.	BPO # 3
Vernonia Wellness team	Formally called the Vernonia School Health Advisory Council (VSHAC).	Vernonia Wellness team was pivotal in the adoption of the Wellness Policy administrative rules for Vernonia School District. Also supported creation of BPO#8	BPO # 8
Karen Ladd, BSN, MS, Administrator	Public Health Authority	Understands the importance of policy, systems, and environmental change and supports a healthy work environment.	BPO # 1,2,3,4,8
Please note that all of the members listed in the Columbia County Healthy Communities Application for 2011-12 serve on a shared TPEP/HC Health Coalition. Those who has influence specifically on TPEP objectives are listed above.			

**Columbia County TPEP Local Program Plan Form
2011-12
Revised for submission June 9, 2011**

Local Health Department: ~~Columbia Health District – Public Health Authority~~ Agency will change to “The Public Health Foundation of Columbia County” as of July 1, 2011

Best Practice Objective: BPO #1, Building capacity for chronic disease prevention, early detection, and self-management

SMART Objective: By June 2012, Columbia County TPEP Coordinator will have participated in at least 15 local level collaborative Health Coalition meetings focused on strategizing and implementing policy, environmental, and/or systems changes to support chronic disease prevention, early detection and/or self-management.

Critical Question: Explain how data describing disparities in health risks and outcomes led you to prioritize the SMART objective, activities or partners identified for this BPO.

American Cancer Society Relay for Life is primarily comprised of participants battling chronic disease or co-survivors of chronic disease. Public Health staff participated on a team at this event for the last ten years, as volunteers. This year, the public health team will have an emphasis on cancer prevention and screening messages, engaging the event coordinator in the process. This will provide a mass amount of outreach and education to a particularly vulnerable population at a more advanced stage of readiness to behavior change.

- Indicates activity will be conducted that quarter
- ✓ Indicates activity was conducted that quarter

Activity Category	Activity Description	1 st	2 nd	3 rd	4 th
Coordination & Collaboration	Partner with HCP Coordinator to develop meeting agendas, facilitate planning sessions, and create work plans for HCP and Health Coalition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Guide Health Coalition efforts at biweekly meetings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	TPEP Coordinator will serve on the St. Helens Safe Routes to School committee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment	Use Relay for Life as an opportunity to conduct an informal assessment of interest in Chronic Disease Management Programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education & Outreach (Development of Local Champions)	Invite Chairperson of American Cancer Society Relay for Life, Columbia County chapter to participate in Health Coalition activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Promote Living Well in all media coverage and at Relay for Life event	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	While working with Vernonia school district on tobacco policy, promote the Health Coalition and Healthy Communities activities. Invite Healthy Communities Coordinator to attend Vernonia Wellness Team meetings to build relationships with members. Recruit Wellness Team to participate in Health Coalition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	TPEP Coordinator will serve on Commissioner’s Health Task Force to network with representatives from the health sector, with the goal of engaging in Health Coalition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Media Advocacy	Advertise Health Coalition events and promote successes through public health website and local media	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Policy Development, Promotion, & Implementation	Work with Public Health Administrator and/or designee to apply for additional funding opportunities to build local capacity for best practice chronic disease prevention, early detection and self-management.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Promote the Oregon Tobacco Quit Line	Include Quit Line information on all Health Coalition presentations and publications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Review monthly Tobacco Quit Line reports to share information about utilization.				
--	--	--	--	--	--

Best Practice Objective: BPO #2, Tobacco free worksites

SMART Objective: By June 2012, at least one additional county property will have a tobacco-free policy in place.

Critical Question: Explain how data describing disparities in health risks and outcomes led you to prioritize the SMART objective, activities or partners identified for this BPO.

Many residents who access county services (ie, court system, jail) are also part of the population with the highest rates of tobacco use and tobacco-related chronic diseases. Newly elected commissioners have expressed interest in Health Coalition activities.

- Indicates activity will be conducted that quarter
- ✓ Indicates activity was conducted that quarter

Activity Category	Activity Description	1 st	2 nd	3 rd	4 th
Coordination & Collaboration	Contact state HPCDP Healthy Worksite staff to discuss current worksite wellness initiatives in Columbia County and Oregon				
	TPEP Coordinator will contact the Director of Human Resources at the county, Columbia County Commissioner and CHDPHA Administrator to identify agency will and readiness and to determine which property will be the focus.				
Assessment	TPEP Coordinator will research existing policies of the property				
	Survey employees to demonstrate support for policy				
	Survey property leadership for support of a policy change process. Identify any existing policy committees				
Education & Outreach (Development of Local Champions)	TPEP Coordinator will request involvement from county commissioner who was a local champion of tobacco cessation in the early 1990s.				
Media Advocacy	Coordinate with Metropolitan Group to identify media calendar and angles for promoting the new policy				
Policy Development, Promotion, & Implementation	Develop (or work with existing) policy and wellness committees to draft a policy and promotion/implementation strategy				
	Finalize policy with Board of Commissioners				
	Provide property signage				
Promote the Oregon Tobacco Quit Line	TPEP Coordinator will provide Quit Line resource cards to the agency				

Best Practice Objective: BPO #3, Implement the Indoor Clean Air Act

SMART Objective: By June 30, 2012, Columbia Health District-Public Health Authority (CHDPHA) will have responded to all complaints of violation of the Smokefree Workplace Law according to the protocol specified in the IGA.

Critical Question: Explain how data describing disparities in health risks and outcomes led you to prioritize the SMART objective, activities or partners identified for this BPO.

By educating the community about their right to report violations, we are able to act on those reports and work towards remediation, thus reducing the exposure of low-income employees to

secondhand smoke. Columbia County has received very few reports of violation from four of the five major incorporated areas, although tobacco use rates are still high.

All activities for this objective will span continuously throughout the entire fiscal year

-  Indicates activity will be conducted that quarter
- ✓ Indicates activity was conducted that quarter

Activity Category	Activity Description	1 st	2 nd	3 rd	4 th
Coordination & Collaboration	Distribute "Celebrate Clean Air" info cards and keep local governmental agencies stocked with cards to increase reporting of violations.				
	Coordinate with TPEP liaison to collect reporting/violation statistics around Oregon.				
Assessment	TPEP staff will participate in DHS/TPEP evaluation activities as assigned, to study compliance with the law.				
	Run a quarterly report from WEMS to determine areas of county in which no complaints have been lodged.				
Education & Outreach (Development of Local Champions)	Reporting information and cessation resources are distributed at every site visit.				
	Fill all order requests through the Tobacco Clearinghouse				
Media Advocacy	Contact businesses who have successfully completed remediation plans to see if they would be interested in receiving praise in local media avenues.				
	Work with local reporters to interview said business owners about the process and successes.				
Policy Development, Promotion, & Implementation	TPEP Coordinator will check WEMS action items every Wednesday.				
	TPEP Coordinator is responsible for all WEMS Correspondence				
	TPEP Coordinator and project assistant will conduct site visits				
	TPEP Coordinator will review and update implementation manual for enforcement activities, quarterly.				
Promote the Oregon Tobacco Quit Line	Quit Line will be included in all tobacco-related media and distributed at site visits.				
	Information about local cessation classes will be distributed at site visits.				

SMART Objective: By June 2012, the number of multi-unit housing properties with smoke-free policies will have increased by 10%

Critical Question: Explain how data describing disparities in health risks and outcomes led you to prioritize the SMART objective, activities or partners identified for this BPO.

Renters include a high proportion of people who experience health disparities so this vulnerable population is supported through the activities of this objective. Working with Clatsop and Tillamook counties to develop a regional smoke-free Northwest Oregon Housing Authority (NOHA) policy. Currently, Columbia County has no NOHA properties. However, the regional team of TPEP Coordinators would like to establish a policy ensuring that any new properties wishing to be a part of NOHA must also implement smoke-free policies.

-  Indicates activity will be conducted that quarter
- ✓ Indicates activity was conducted that quarter

Activity Category	Activity Description	1 st	2 nd	3 rd	4 th
Coordination & Collaboration	TPEP Coordinator will participate in regional NOHA meetings held quarterly in Columbia County				
	Coordinator will discuss progress on regional NOHA policy for properties with smoke-free policies, at least quarterly				
	Direct any questions concerning NOHA regional process or policies through Clatsop County TPEP Coordinator				
	Make contact with at least three landlords or multi-unit housing managers/owners per quarter				
Assessment	Check NOHA website to identify properties in Columbia County, at least once per quarter				
	Complete quarterly "Tracking Form for Multi-unit Properties that have Adopted No-Smoking Policies"				
	Complete quarterly "Rental Ad Tracking Tools"				
	Work with Health In Sight, LLC, to assess landlords' readiness to adopt policies and to survey tenants regarding their support for no-smoking rules.				
Education & Outreach (Development of Local Champions)	Work with landlords to ensure those with no-smoking policies are listing that as an amenity in their vacancy postings				
	Refer renter to the Fair Housing Council of Oregon's Smokefree webpage through an ad in local papers' rental ad section by including a short listing called "Things to consider when finding a place to rent"				
Media Advocacy	Work with local media health advocate (Josey Bartlett) to promote the benefits (to tenants and to landlords) of smoke free housing				
Policy Development, Promotion, & Implementation	Use "A Landlord's Guide to No-Smoking Policies" to provide assistance to property owners/managers as they adopt no-smoking rules in their rental agreements.				
	Work with landlords to develop an implementation plan including resident notice time, lease transition, signage, and staff training for enforcement.				
Promote the Oregon Tobacco Quit Line	Quit Line will be included in all tobacco-related media.				
	Information about local cessation classes will be distributed at meetings.				

Best Practice Objective: BPO #8, Tobacco-free schools

SMART Objective: By June 2012, Vernonia School District will have improved their Tobacco-Free Campus Policy from a "B" grade to an "A" grade.

Critical Question: Explain how data describing disparities in health risks and outcomes led you to prioritize the SMART objective, activities or partners identified for this BPO.

Vernonia School District has the highest rate of tobacco use among students, in the county. The K-12 property is currently the community center, used for summer events and festivals. By improving the campus policy for school and non-school-related activities, exposure to secondhand smoke will drastically decrease. Student exposure to smokeless tobacco in community settings will also decrease. The Wellness Team and superintendent have agreed to move forward with this objective and have reviewed the proposed activities.

-  Indicates activity will be conducted that quarter
-  Indicates activity was conducted that quarter

Activity Category	Activity Description	1 st	2 nd	3 rd	4 th
Coordination & Collaboration	Coordinator will work with the Vernonia School District Wellness Team to review the amendments necessary to improve the letter grade of the policy. Wellness Team member list is attached				
Assessment	Download and examine the tobacco policy using the ALAO database and district profile				
	Review gold-standard model policies				
	Conduct a review of student tobacco use data				
Education & Outreach (Development of Local Champions)	Invite the local newspaper editor to participate in the wellness team policy revision process.				
	Provide cessation materials to school staff and Vernonia Prevention Coalition director				
Media Advocacy	Provide interviews and data to local newspaper to do a spread on risks of tobacco use, resources, and school policy				
	Engage a student who has recently quit tobacco, for a feature in the local paper?				
Policy Development, Promotion, & Implementation	Create proposed policy for Wellness Team review (new policy will be a revision of Gold-Standard)				
	Present policy amendments to school board				
	Provide signs for school district				
Promotion of Quit Line	TPEP Coordinator will provide school staff with cessation resources, for staff and to distribute to students.				
	Assess and promote cessation benefits for school staff				
Education & Outreach (Development of Local Champions)	Engage student health advocacy group to promote the new policy				

ATTACHMENT 2

Healthy Communities Program Annual Plan
(Formerly Tobacco-Related and Other Chronic Diseases/TROCD)

Plans are created and submitted to the state DHS Office, annually.

Columbia Health Coalition

Briefly summarize how community leaders were consulted to select the strategic direction and priorities, including those related to reducing health disparities, for the Local Program Plan for this grant application. Add rows as needed.

Community Leader, Partner, Stakeholder or other Advisor consulted	Name of Organization	Briefly describe how this Advisory Council member helped guide the development of the Local Program Plan.	If applicable, note the BPO(s) in which this individual or organization will continue to be involved.
Name of individual Bill Blank, Volunteer	Scappoose Farmers Market Manager & Scappoose planning commission Health Coalition member	Knowledgeable in farmers market and increasing access to nutrition. Provides guidance to the Columbia Health Coalition in making contacts.	
Sherrie Ford MPH, Tobacco Prevention & SBHC Coordinator	Columbia Health District – Public Health Authority Health Coalition member	Worked with HC Coordinator to identify areas for collaboration between programs. Also works with Vernonia Wellness Team and received input from the team for approving BPO#3	BPO # 2 & 3
Kjerstin Gould, Director	Clatskanie Together Coalition Health Coalition member	Representative from North County. Health Coalition members help set the priorities (focus on school-aged students) for HC workplans.	In the future may have resources/contacts for BPO 1
Leeann Grassetth, BS, CPS, Certified Prevention Specialist	Columbia Community Mental Health Health Coalition member	Prevention specialist, knowledgeable on best practice. Health Coalition Partner Coach (through ACHIEVE funding). Works with many of the school districts.	BPO # 3
Gary Heide, Vice Chair	Columbia Health District Board Health Coalition member	Elected official Health Coalition members help set the priorities (focus on school-aged students) for HC workplans.	BPO #2
Trish Hora, RN	St Helens School District Nurse Health Coalition member	Providing valuable guidance from the school district's perspective.	BPO # 3 the plan is to replicate effort in other communities.
Heather Lewis, Volunteer	Vernonia Health Board and Prevention Coalition – Volunteer Health Coalition member	Representative from North County and provides valuable contacts to the community	BPO # 3
Breanne Mares, Intern	Columbia Community Mental Health Health Coalition member	Health Coalition members help set the priorities (focus on school-aged students) for HC workplans.	
DeAnna Pearl, Director	Vernonia Prevention Coalition Health Coalition member	Representative from North County and provides valuable contacts to the community. Knowledgeable in best practices.	BPO # 3

Brenda Peer, RN	Scappoose School District Nurse Health Coalition member	Providing valuable guidance from the school district's perspective.	BPO # 3 the plan is to replicate effort in other communities.
Jenny Rudolph, Extension Educator, Family & Community Health, 4-H	OSU Extension office Health Coalition member	Provides guidance to the LHD for the Living Well Program and is interested in becoming a trainer.	BPO #1
Stakeholders who have influenced the H.C. objectives who are not Health Coalition members:			
Vernonia Wellness team	Formally called the Vernonia School Health Advisory Council (VSHAC).	Vernonia Wellness team was pivotal in the adoption of the Wellness Policy administrative rules for Vernonia School District. Also demonstrated interest in Safe Routes to School.	BPO # 3
Karen Ladd, BSN, MS, Administrator	Columbia Health District – Public Health Authority	Understands the importance of policy, systems, and environmental change and supports a healthy work environment.	BPO # 2
Sheri Duren, WIC breastfeeding coordinator	WIC breastfeeding Coordinator	Understand the importance and is knowledgeable on breastfeeding. Will direct the environmental changes necessary to implement a CHD breastfeeding policy.	BPO # 2

**Columbia County Healthy Communities Local Program Plan Form
2011-2012**

Local Health Department: ~~Columbia Health District- Public Health Authority-Agency~~ will change to "The Public Health Foundation of Columbia County" as of July 1, 2011

BPO 1: Infrastructure for Self Management Programs and Tobacco Cessation Resources

SMART Objective: By December 2011 one new Living Well program will be offered and a second new Living Well Program will be offered by June 2012 in Columbia County.

Critical Questions:

1. Explain how data describing disparities in health risks and outcomes led you to prioritize the SMART objective, activities or partners identified for this BPO?

Resources for chronic disease management do not currently exist in Columbia County. LHD has struggled to identify partner organization; therefore, LHD purchased the Stanford Licensing in 2010-11. To recruit and promote the new Living Well opportunity, targeted effort will be made at the 2011 Relay for Life event in 2011-12 fiscal year. Relay for Life is an American Cancer Society event, attended in large by those with a personal history of chronic disease. This is the most densely populated event (by the target population) in the county, and an avenue for building partnerships with potential host agencies as well.

2. Please briefly describe how this workplan is related to your Community Assessment and 3-Year Community Plan?

Provision of new Living Well programs is written into the 3 year plan.

Legend:					
<input type="checkbox"/>	Indicates activity will be conducted that quarter				
<input checked="" type="checkbox"/>	Indicates activity was conducted that quarter				
Activity Categories	Activity Description	1st	2nd	3rd	4th
Coordination & Collaboration	1. Continue involvement on the "Marketing and Recruitment Living Well Group" to support the program infrastructure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment	2. Work with TPEP coordinator to assess current Quitline data for Columbia County. Create Columbia County-specific graphs using the state provided Quitline reports to monitor who is being reached.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination & Collaboration	3. Coordinate with the Vernonia Health Board to ensure that if they are granted FQHC status in August 2011 that Clinic Administration is aware of the resources through Patient Self Management Collaborative (PSMC). FQHC is anticipated to open Dec 2011. Coordinate with PSMC to identify details tasks.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination & Collaboration	4. Promote Living Well at the monthly Relay for Life coaches meetings and main event in July. Engage the Relay for Life Chair in the Health Coalition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment	5. During the Relay for Life event stock the Health Squad booth (team composed of health department staff) with Living well posters and brochures. On Saturday during the busiest time post questions for relay participant to get an idea if there is an interest. Sign-up sheet available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination & Collaboration	6. Present Relay results to Columbia Health Coalition glean ideas from Health Coalition on other potential partnering organizations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination & Collaboration	7. Based on list of identified potential partner organizations meet with each one and see if the organization is interested in host Living Well program in the 1 st six months and 2 nd six months.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination & Collaboration	8. Columbia Health Coalition will use the momentum gained to identify and recruit other organizations,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	champions, partners interested in supporting Living Well.				
Outreach & Education	9. Provide updated information about self management program to referral organizations such as clinics, case managers and others. (At least one per quarter)				
Media Advocacy	10. Strategize with Metro Group before and after the Living Well workshop to recruit participants and encourage participants to tell their story as a way to promote Living Well.				
Outreach & Education	11. Give presentations to civic organizations. Strive for 1-2 presentations per quarter. Target audience will vary based on the need and interest ie: logistics, recruitment and outreach.				
Coordination & Collaboration	12. Collaborate with the organizations who have expressed interest from the presentations to create a Living Well Plan for the following year: Recruit coordinator, leader training, and workshops.				
Coordination & Collaboration	13. Assist with coordination of the leader training and help with confirming logistics.				
Media Advocacy	14. Work with local newspapers to express the importance of having Living Well in our communities.				
Coordination & Collaboration	15. Attend the Living Well Forum				

BPO 2: Health Worksites

SMART Objective: By June 2012 The Public Health Authority will have a policy that is promoted and enforced to support breastfeeding women, including designated, adequate space for nursing mother and flexible scheduling to support milk expression during work.

Critical Questions:

1. Explain how data describing disparities in health risks and outcomes led you to prioritize the SMART objective, activities or partners identified for this BPO?

CHD-PHA may be used as an example for other worksites that do not fall under the state breast feeding law (due to small number of employees).

2. Please briefly describe how this workplan is related to your Community Assessment and 3-Year Community Plan?

CHD-PHA can set the precedence for other small businesses in our community to implement policy change to positively affect the health and wellness of their employees.

Note: The Public Health Foundation has an intergovernmental agreement with Columbia County. The Public Health Authority staff is governed by the Foundation board. Public Health Staff consist of 18 employees. Public Health staff is not a part of a union nor do we have a human resource department. Our hopes are to use the momentum from passing a wellness policy at Public Health to encourage other small businesses to consider the importance of employee wellness.

Legend					
	Indicates activity will be conducted that quarter				
✓	Indicates activity was conducted that quarter				
Activity Category	Activity Description	1 st	2 nd	3 rd	4 th
Assessment	1. Research “The Business Case for Breast feeding: Steps for Creating a Breastfeeding Friendly Worksite, Health Resources and Service Administrators.” http://www.womenshealth.gov/breastfeeding/government-programs/business-case-for-breastfeeding/index.cfm .				
	2. Talk to Public Health administrator to determine agency will.				

	3. Contact Nursing Mother Counsel of Oregon for support through the process. http://www.nursingmotherscounsel.org/				
Coordination & Collaboration	4. Work with WIC program on identifying a strategy for a breastfeeding policy and environmental changes.				
Coordination & Collaboration	5. HC teams up with WIC to conduct an informal survey among Public Health staff.				
Policy Development, Promotion, Implementation	6. Create policy utilizing feedback from Staff, Administrator, fiscal manager, and resources available on the DHS website.				
Coordination & Collaboration	7. Present survey results and solicit feedback on sample policy ideas from key stakeholders.				
Coordination & Collaboration	8. Finalize policy and present at staff meeting and ask for input.				
Outreach & Education	9. Present policy to the CHD – Board for approval. The CHD board has the ability to pass or reject policy during the same board meeting.				
Outreach & Education	10. Share process with the Columbia Health Coalition and local Chambers of Commerce.				
Media Advocacy	11. Praise the Health Department through local newspapers and extend an offer to be a resource to other local businesses.				

BPO 7: Healthy Schools

SMART Objective: By June 2012, Vernonia School District will have a plan in place for Safe Routes to School.

Critical Questions:

1. Explain how data describing disparities in health risks and outcomes led you to prioritize the SMART objective, activities or partners identified for this BPO?

Ensuring students have safe routes to school will increase the amount of opportunity students have for physical activity and therefore reducing the students who are at risk for developing chronic conditions.

2. Please briefly describe how this workplan is related to your Community Assessment and 3-Year Community Plan?

The Columbia Health Coalition recognizes our youth as a high priority and agreed to incorporate the Safe Routes to School Program into our 3 year plan.

Legend					
		Indicates activity will be conducted that quarter			
	✓	Indicates activity was conducted that quarter			
Activity Category	Activity Description	1 st	2 nd	3 rd	4 th
Assessment	Research the Safe Routes to School Program and Identify necessary components.				
	Consult the following resources throughout the year: 1. http://www.saferoutesinfo.org/educatorsguide 2. http://www.saferoutesinfo.org 3. http://www.walknbike.org/neighborhood-navigators				
Coordination & Collaboration	Talk to Vernonia Superintendent about their readiness and funding available to implement safe routes to school. Share with the superintendent how the Columbia Health Coalition can support their effort.				
Coordination & Collaboration	Share researched information with the Vernonia Wellness team and Vernonia Prevention Coalition. The Chair of the Wellness team is dedicated to safe routes to school. With the passing of the bond for the new schools the community is ready.				
Coordination & Collaboration	Work with the Vernonia Wellness team to ensure the new schools are designed with Safe Routes to School in mind. New schools are expected to open June 2012.				
Education & Outreach	Identify members of the Vernonia Wellness team to take on the leadership responsibility and form a task force that will also include members of the community as well as partnering organization from				

	the City of Vernonia.				
Coordination & Collaboration	Work with task force to ensure a plan is in place before breaking for summer vacation.				
Coordination & Collaboration	Use momentum from the task force to influence the Vernonia City planner to look at transportation policy so opportunities for safe walking and biking are sustainable.				
Media Advocacy	Work with Vernonia Wellness Team and Scott Laird (Vernonia Independent newspaper) to give targeted messages on safe walking and bicycling. Also to provide maps of the safe routes to the new school grounds.				
Promote the Oregon Tobacco Quit Line	The quitline and the Tobacco Free campus policy will be promoted through the media to encourage people to quit and reduce the exposure the kids may have on their way to school.				

ATTACHMENT 3

Immunization Comprehensive Plan

Immunization Comprehensive Triennial Plan

**Due Date: May 1
Every year**

**Local Health Department:
Plan A - Continuous Quality Improvement: Reduce Vaccine Preventable Disease
Calendar Years 2009-2011**

Year 1: July 2009-December 2009						
Objectives	Activities	Date Due / Staff Responsible		Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p>A. Increase 4th Dtap at CHD-PHA by 1% each year for the next three years</p>	<p>Use most recent AFIX assessment data as the baseline</p> <p>Run recall report monthly to identify patients needed 4th Dtap ages 12 months to 6 years</p> <p>Call, email, or mail post cards to patients identified on monthly recall report to schedule appointments</p> <p>Use minimum interval forecasting and scheduling for 4th Dtap</p> <p>Fully screen each patients for immunizations at every visit and immunize as needed</p> <p>After patient appointment, forecast for future shots due and schedule a next appointment before patient leaves clinic</p> <p>Provide written reminder appointment card for next scheduled appointment before patient leaves clinic</p>	<p>Date</p> <p>1st Friday</p> <p>Monthl y</p>	<p>Staff</p> <p>Clerk</p> <p>Clerk</p>	<p>AFIX Baseline set Recall lists generated monthly starting: <i>Started July 2009</i></p> <p>Contact made to patients monthly; review by lists printed & filed</p> <p>Minimum interval forecasting implemented by Clerk, Office Manager of Coordinator</p> <p>Forecasting for immunizations at every patient visit implemented by Clerk, Office Manager or Coordinator</p> <p>Process for forecasting & scheduling patients before leaving office implemented by Clerk and Office Manager</p> <p>Written appointment reminder cards given at every newly scheduled appointment by Office Manager, Clerk</p>	<p>Afix baseline set</p> <p>Recall lists generated monthly and postcards sent as reminders for missing 4th Dtaps</p> <p>Forecasts done for each client at each visit</p> <p>Appointments for next immunizations due are scheduled before parents leave clinic</p>	<p>Recall lists and postcards contribute to significant outreach to capture missing 4th Dtaps</p> <p>Forecasting at each visit allows for nurse to educate parents about next immunizations due so office staff can schedule appointments and write reminder cards for next immunizations due before clients leave the office</p>

	<p>Phone call reminder to confirm patient appointments for the next day(s)</p> <p>Continue partnership with WIC to screen for immunizations during WIC appointments</p> <p>Continue walk-in immunization process for identified WIC patients needing immunizations</p> <p>Give all shots due unless truly contraindicated</p> <p>Continue counseling parents/guardians that may be hesitant for child to receive all shots due at appointment</p> <p>Use McDonald vouchers for incentives for immunizations</p> <p>Coordinate and travel to school clinics for immunizations: outreach during school exclusion, preschool round-ups</p> <p>Use media to advertise for immunization clinics: flyers and newspaper ads.</p>	Date	Staff	<p>Appointment reminder phone calls completed <i>once a week the day before appointments</i> by Clerk or Carolina</p> <p>Process for walk-in immunization appointments from WIC referral implemented, WIC staff responsible for identifying and referring WIC clients to immunizations when shots due</p> <p>Process for counseling for vaccine hesitant parents/guardians at appointments implemented, IRIS generated forecast used as teaching tool by RN to promote up to date status of clients, Coordinator each visit</p> <p>Purchase McDonald Vouchers</p> <p>McDonald Vouchers used for incentive for completing 4th dtap/</p> <p>School Immunization Clinics Completed: <i>#3 from July 2009-Jan 2010 at Rainier, Vernonia and Clatskanie by Coordinator, RN</i></p> <p>Advertising for immunization clinics implemented: <i>Letters sent home to parents by school nurse and local newspaper ads, Vernonia Clatskanie</i></p>	<p>Appt reminder calls are made by immunizations staff the day before appointments.</p> <p>WIC staff are responsible for identifying and referring their clients to immunizations staff When shots are due Use of IRIS forecast is used to educate parent on when child will be UTD CHD immunizations coordinator is available to assist local schools with kindergarten round-ups and vaccination clinics at the schools to prevent school exclusions</p>	<p>Making reminder calls helps with rescheduling clients who are unable to keep the original appt.</p> <p>WIC clients schedule immunizations appointments to coincide with WIC appointments.</p> <p>Forecasting gives parents hands on info about bringing childhood immunizations up to date and is an effective tool in increasing up to date rates. Vouchers not yet purchased Three clinics completed at schools in the county</p> <p>Newspaper ads and school nurse letters are successful forms of advertising available clinics in the schools</p>
--	---	------	-------	--	--	---

<ul style="list-style-type: none"> ❑ Continue to fully screen each patient for immunizations at every visit and immunize as needed. ❑ Continue to, forecast for future shots due after patient appointment and schedule a next appointment for the patient before they leave. ❑ Continue to provide written reminder appointment card for next scheduled appointment before patient leaves clinic. ❑ Phone call reminder to confirm patient appointments for the next day(s). ❑ Continue partnership with WIC to screen for immunizations during WIC appointments. ❑ Continue walk-in immunization process for identified WIC patients needing immunizations ❑ Give all shots due unless truly contraindicated ❑ Continue counseling guardians that may be hesitant for child to receive all shots due at appointment ❑ Media to advertise for immunization clinics: flyers and newspaper ads. 			<ul style="list-style-type: none"> ❑ Forecasting for immunizations at every patient visit continued. ❑ Forecasting & scheduling patients before leaving office continued. ❑ Written appointment reminder cards given at every newly scheduled appointment by Clerk as well as above. ❑ Appointment reminder phone calls completed <i>weekly before appt by Carolina.</i> ❑ Walk-in immunization appointments from WIC referral continued ❑ Counseling for vaccine hesitant parents/guardians at appointments continued by Coordinator, Clerk and Office Manager. ❑ Use of IRIS forecast with parents at time of visits to encourage all shots due and as a guide for setting next appt, with reminder card given by Coordinator or Office Manager 	<p>Ongoing</p> <p>Ongoing</p> <p>Clerk ordered reminder stickers for parent home calendars in April 2010</p> <p>Ongoing and new clerk has taken over previous Clerk's tasks</p> <p>WIC walk-in Immunization appointments ongoing</p> <p>Training for new immunizations clerk on outcome measures to increase 4th Dtap up to date rates</p> <p>Ongoing</p>	<p>4th Dtap reminder posters are up in key locations around the clinic</p> <p>In-office training for new immunizations clerk completed on 4-6-2010</p> <p>Additional resource of book "Vaccinating Your Child, questions and answers for the concerned parent" is available to immunizations staff to further educate parents</p> <p>Author, Cynthia Good, MD, MPH</p>
<ul style="list-style-type: none"> ❑ Use McDonald vouchers for incentives for immunizations ❑ Continue coordination and travel to school clinics for immunizations: outreach during school exclusion, preschool round-ups ❑ Continue to use media to advertise for immunization clinics: flyers and newspaper ads. ❑ Contact local library to explore opportunities to partner on Immunizations 			<ul style="list-style-type: none"> ❑ Purchase McDonald Vouchers ❑ McDonald Vouchers used for/ <i>incentive to complete 4th dtap</i> ❑ School Immunization Clinics Completed: <i>#3 at Rainier, Vernonia and Clatskanie.</i> ❑ Advertising for immunization clinics implemented: <i>Letters sent by school nurse and local newspapers</i> ❑ Library contacted on <i>1/28/2010 - John will return call, if interested in partnering with CHD for shot clinic and book give away</i> 	<p>McDonalds Vouchers system started on 2-10-2010</p> <p>School Immunizations clinics continued, next one at Scappoose in May</p> <p>Ongoing</p>	<p>Parents and children alike are very fond of the McDonalds voucher system reward for completing a 4th Dtap</p> <p>County Librarian was contacted to explore a free book program for children who are up to date on the 4th Dtap. The Librarian made a referral to another community agency on CHD-PHA's behalf to obtain free books for up to date immunizations clients.</p>

Year 3: January 2011-December 2011					
Objectives	Activities	Date Due / Staff Responsible	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. Increase 4:3:1:3:3 rates by 1% each year or maintain a rate of greater than or equal to 90%.	<p>Use most recent AFIX assessment data as the baseline</p> <p>Have Oregon Immunization Program do an AFIX visit to discuss immunization rates for 2010 data</p> <p>Continue to run recall report monthly to identify patients needed 4:3:1:3:3 ages 12 months to 6 years</p> <p>Continue to call, email, or mail post cards to patients identified on monthly recall report to schedule appointments</p> <p>Continue to use minimum interval forecasting and scheduling for 4:3:1:3:3</p> <p>Continue to fully screen each patients for immunizations at every visit and immunize as needed</p> <p>Continue coordination and travel to school clinics for immunizations: outreach during school exclusion, preschool round-ups</p> <p>Continue to use media to advertise for immunization clinics: flyers and newspaper ads</p>		<p>AFIX Baseline set Dates of OIP AFIX review visit: <i>Apr 2011, Coordinator to request visit in early 2011</i></p> <p>Recall lists generated monthly by Clerk</p> <p>Contact made to patients monthly; review by lists printed & filed, by Clerk</p> <p>Minimum interval forecasting continued, by Coordinator, Clerk or Office Manager</p> <p>Forecasting for immunizations at every patient visit continued by Clerk Coordinator or Office Manager</p> <p>School Immunization Clinics Completed: <i>Clinics held at schools as requested by school nurses at K-round ups or Spring and Fall Immunization clinics or exclusion immunization clinics.</i></p> <p>Advertising for immunization clinics implemented: <i>by school nurse letters and local newspaper ads, reader boards</i></p>	<p>Most recent AFIX data is not yet available, 4/1/11</p> <p>Plan to request Afix visit on hold due to budget concerns about funding of local public health immunization program</p> <p>New ALERT IIS is live and county health staff has been trained. County info needs to be entered by super-user Lori Peterson Rainer Health Center Staff has begun training for new ALERT</p> <p>Micaela will run recall reports, print labels, letters and mail letters and file reports</p> <p>Forecasts are printed at each pt. visit and used as education tool, and as next apt. guide at front desk as patient leaves clinic.</p> <p>Public health immunization program has been building partnerships with county schools to provide immunization clinics for uninsured children. Two clinics provided in 2010 at school nurse request and advertised in local paper.</p>	<p>Data presented by state at first AFIX training in Jan., 2010, reflected unmet goals for missed shots and 4:3:1:3:3 UTD rates</p> <p>By updating our client information in ALERT IIS it is possible that reports may reflect the counties' AFIX rates more accurately and show an improvement in UTD rates and a decrease in missed shot rates</p> <p>Using forecaster as teaching tool for parents is a great resource, to keep vaccination rates up and plan for next immunization appt. while client is still in the office</p> <p>We in Columbia County are in transition as our Health District Board is dissolving and the Columbia County Commissioners are deciding who will administer PH services in the county. We should know by May 26th the fate of public health services in Columbia County</p>

<p>B. Reduce Missed Shot Rate by one percent or maintain rate of less than or equal to 10%</p>	<p>Continue to, forecast for future shots due after patient appointment and schedule a next appointment for the patient before they leave</p> <p>Continue to provide written reminder appointment card for next scheduled appointment before patient leaves clinic</p> <p>Phone call reminder to confirm patient appointments for the next day(s)</p> <p>Continue partnership with WIC to screen for immunizations during WIC appointments</p> <p>Continue walk-in immunization process for identified WIC patients needing immunizations</p> <p>Give all shots due unless truly contraindicated</p> <p>Continue counseling guardians that may be hesitant for child to receive all shots due at appointment</p> <p>Use McDonald vouchers for incentives for immunizations</p>			<p>Forecasting & scheduling patients before leaving office continued, by Clerk, Office Manager</p> <p>Written appointment reminder cards given at every newly scheduled appointment by Clerk or Office Manager</p> <p>Appointment reminder phone calls completed 7 times a week before appt: review of schedule by Clerk</p> <p>Walk-in immunization appointments from WIC referral continued</p> <p>Counseling for vaccine hesitant parents/guardians at appointments continued at time of visit by Coordinator, Clerk, Office Manager using IRIS forecast as tool</p> <p>Purchase McDonald Vouchers Thalia McDonald Vouchers used for/ incentive to complete 4th Dtap</p>	<p>Use of recall lists and reminder postcards results in missed appointments being rescheduled. Forecasting is a continued outcome measure, because without an accurate record of what shots are due and when next shots are due we are not able to educate parents and make next appointments while the clients are in the office. Most parents make the next appointment while still in the office.</p> <p>We received the newest version of "The Parent's Guide to Childhood Immunizations" and have mailed two copies to vaccine hesitant families March 10, 2011 and two copies handed out during patient visits.</p>	<p>Educating parents at the time of visit by listening to questions from vaccine hesitant parents and by using a printed forecast and up to date immunization materials results in more parents allowing immunizations to be given at the time of visit and will improve the missed shots rate.</p>
---	--	--	--	--	--	---

Immunization Comprehensive Triennial Plan

Local Health Department:
Plan B – Community Outreach and Education
Calendar Years 2009-2011

<p>Due Date: May 1 Every year</p>
--

Year 1- 3: July 2009-December 2011						
Objectives	Activities	Date Due / Staff Responsible		Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
1. Promote alert registry in Columbia County from July 2209 – December 2011	Advise existing and new alert users about the expansion to a lifespan registry	Ongoing	Mary	Copy of e-mails sent to provider systems and to school nurses	To be completed for the CY 2009 Report	To be completed for the CY 2009 Report
2. Increase vaccine promotion to drug/ETOH community	Talk to treatment center staff regarding vaccines and leave information	Quarterly calls or visits	Mary	Log of # of calls and e-mails	To be completed for the CY 2009 Report	To be completed for the CY 2009 Report

Immunization Comprehensive Triennial Plan

**Local Health Department:
Plan B – Community Outreach and Education
Calendar Years 2009-2011**

Due Date: May 1 Every year

Year 2: January-December 2010						
Objectives	Activities	Date Due / Staff Responsible	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes	
A. Promote Alert Registry in Columbia County	<p>Advise existing and new Alert users of the expansion to a lifetime registry</p> <p>Identify sites using alert</p> <p>Promote Alert use at onsite visits of schools at Fall Survey</p>	<p>At every contact with childcare facilities,</p> <p>When alert info is shared</p> <p>For Fall Survey time</p>	<p>Staff Mary</p> <p>Mary</p> <p>Mary</p>	<p>Ask at with every phone call to or from exclusion sites , during exclusion time Fall 2010, about Alert use. Shared idea with Stacy Matthews Fall 2010, about having a check box on the IRIS exclusion sites information page to show if the site is using Alert or not. Mary instructed Vickie Weaver at South Columbia Family School about printing CIS forms from Alert 10/6/2010 Peggy Hillman instructed Columbia County Christian School on Alert at Fall Survey site visit. 2010</p>	<p>Continuing to instruct on Alert use when non-users are identified, through exclusion work. Response to using Alert is positive, except for initial hesitancy about using a program that is 'something new' The childcare agencies are very happy with it because it enables them to access records that parents forget to bring in to update children's' records</p>	<p>When new sites sign up for the Alert registry there is a decrease in workload for myself reviewing records at exclusion time, because the site has access to the same up to date information that the county has access to. Fewer records need to be turned in for review., before sites began using Alert, records were received by public health to review that were actually complete after a search of Alert.</p>
B. Increase vaccine promotion to drug-ETOH community	<p>Newspaper PSA in Columbia County News Advertiser</p> <p>Mail Hep A ,B,C info and vaccination info to community partners</p>	<p>Quarterly</p> <p>Quarterly</p>	<p>Pam</p> <p>Mary</p>	<p>PSA in newspaper Wednesday March 31st, 2010 Hep testing and vaccination and flu clinics Oct. 2010</p> <p>Mailed to three community partners on Oct. 01, 2010 to nurse at County jail, Community Mental Health and Community Drug and Alcohol Services</p>	<p>As a result of newspaper PSA no requests for vaccinations from high risk persons were received.</p> <p>As a result of information mailed to community partners involved with high risk clients, clients can be educated on local services (testing and vaccination for Hep) by their community partner providers.</p>	<p>Even though there was no increase in vaccinations for high risk individuals for Hep A and B , the information is being disseminated about our services in the local community.</p> <p>We continue to vaccinate many area care providers for Hep A and B which is paid for by their employers. The plan is to continue to publish PSA in local county newspapers about public health vaccination services for high risk populations, and give updates on available services to community partners to share with their high risk clients.</p>

Immunization Comprehensive Triennial Plan

**Local Health Department:
Plan B – Community Outreach and Education
Calendar Years 2009-2011**

<p>Due Date: May 1 Every year</p>
--

Year 3: January 2011-December 2011						
Objectives	Activities	Date Due / Staff Responsible		Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. Promote Alert Registry in Columbia County	Advise existing and new Alert users of the expansion to a lifetime registry and recruit 5 new users to train for the system Promote new Alert system trainings	By end of Year 2011	Mary	Record keeper for Bryant House instructed on Alert use January of 2011 and site began using Alert.	Daycare and children's facilities who have begun to use Alert love it because it helps them so much to complete their immunization records. Would like to see the state IRIS school exclusion computer program include a check box to note use of Alert for each site Sites that have been using Alert will need to complete training for the new system and Columbia County Health Department wants to play a role in getting training information out to the sites so they will be up and running for Fall exclusion records review.	Goal by end of 2011 is to have a total of 5 new sites start using the Alert website.
	Develop a system or checklist of exclusion sites to identify which sites are not using Alert	Fall 2011	Mary	At start of Fall exclusion season 2011 provide information on upcoming state trainings on Alert for daycares and children's facilities in Columbia County		
	Promote Alert use at onsite visits of schools and children's facilities during Fall survey visits.	Fall 2011	Mary	Printed a current list of exclusion sites to use to call sites and note Alert use Fall 2011		
		Fall 2011	Mary or state Immunization staff present	Letters announcing an ALERT training were sent 6/24/11 Give handout on Alert use or instruct from site school law handbook on Alert use during Fall Survey site visits.		
B. Increase Vaccine promotion to drug – ETOH community	Gather educational materials on vaccine promotion	Annually	Mary	State supplied information received and distributed	Distribution of educational materials to community partners that are shared with high risk populations in the county helps promote steps that a high risk individual can take to prevent further health problems	
	Contact community partners and provide information on public health vaccination services for high risk populations	Quarterly	Mary	Distributed Hep A and Hep B vaccination information to Columbia County jail in person on 5/19/2011		

