



*DOUGLAS COUNTY*  
**HEALTH AND SOCIAL SERVICES**

December 1, 2011

Tom Engle  
Department of Human Services  
800 N.E. Oregon Street, Suite 930  
Portland, OR 97232

Dear Mr. Engle:

Enclosed please find Douglas County's Public Health Annual Plan for 2011/2012, which is being submitted pursuant to ORS 431.385. This plan has been prepared according to your instructions and assures that the activities defined in ORS 431.375 - 431.385 and ORS 431.416 are performed. If you have any questions or need further information, please contact me at (541) 440-3625.

Douglas County submits this Annual Plan with the understanding that various staff, programs, and plans will be evolving or be eliminated to match state and federal funding available come July 1, 2012. At this time we plan to provide public health services as outlined in this annual plan. We will continue to work with CHLO on how to provide public health services with limited funding.

Sincerely,

Peggy Madison, Administrator  
Douglas County Health and Social Services

## I. EXECUTIVE SUMMARY

Douglas County Health and Social Services (DCHSS) is a steward of public health in Douglas County and is responsible for local leadership in the promotion of policies, systems, and environments that promote health and prevent illness, disease and injury. Accordingly, DCHSS defines its public health responsibilities by the nationally recognized Ten Essential Public Health Functions, which describe what every person, regardless of where they live, can reasonably expect from their Local Public Health Authority. These Functions provide foundation for Public Health in Douglas County and Oregon.

1. **Monitoring health status** to identify community health problems
2. **Diagnosing and investigating** identified health problems and health hazards in the community
3. **Informing, educating, and empowering** people about health issues
4. **Mobilizing community partnerships** to identify and solve health problems
5. **Developing policies and plans** that support individual and community health efforts
6. **Enforcing laws and regulations** that protect health and ensure safety
7. **Linking people to needed health services** and assuring the provision of health care when otherwise unavailable
8. **Assuring a competent public health and personal health care workforce**
9. **Assessing effectiveness, accessibility and quality** of personal and population-based health services
10. **Researching for new solutions** to health problems

Douglas County's expansive geography and rural demographics require the use of different strategies to fulfill the essential public health functions than used in urban areas. The economy of scale that helps to ensure that these essential functions are accomplished in urban areas does not exist in Oregon's rural jurisdictions. As a consequence, competing priorities, fiscal constraints, and distance from technical and research centers impose limitations on our capacity to address the complexity of each essential function.

Douglas County, as with many rural jurisdictions, faces the challenges of an aging population, high rates of unemployment and poverty, few educational opportunities, high rates of tobacco and other drug use, and fewer local resources dedicated to addressing these and other known health risk factors. The scarcity of health resources, compounded by limited public transportation and long travel distances, is a problem that continues to affect the health of our community.

The continued economic downturn has led to funding cutbacks that jeopardize our ability to provide the core public health services. County public health programs have historically relied on federal funding. In 2009-2010, Douglas County experienced a 10 percent reduction in safety

net funding. The County Board of Commissioners directed the Public Health Division to cut approximately 35% or \$300,000 from the Public Health Division budget. With reduced general fund support, DCHSS will rely more on state funding, grants, Medicaid-match programs, and revenue from service provided. There is no local property tax funding to support public health. Douglas County government continues to consider options to increase revenue, streamline programs, and cut services.

Douglas County submits this Annual Plan with the understanding that staff, programs, and plans will evolve or be eliminated to match state and federal funding available on July 1, 2012. The Health Department will continue to work with CHLO to identify priorities and develop plans to provide public health services without adequate funding.

## II. ASSESSMENT

The following indicators provide a description of the public health issues and needs in Douglas County.

### Geography

Douglas County extends west to east from sea level at the Pacific Ocean to 9,182-foot Mt. Thielsen in the Cascade Range. Douglas County covers an expansive 5,071 square miles. Douglas County is comprised of 12 incorporated cities Canyonville, Drain, Elkton, Glendale, Myrtle Creek, Oakland, Reedsport Riddle, Roseburg, Sutherlin, Winston, and Yoncalla. About 70% of the County's population lives in cities and unincorporated areas outside of the Roseburg core area – areas designated by the [Oregon Office of Rural Health as areas of Unmet Health Care Need](#).

### Population

Douglas County's population has grown to 107,690, up from the county's 2000 Census count of 105,240 ([Portland State Population Research Center](#)). [Forecasts](#) based upon 2000 Census data predict that Douglas County's population will grow to over 117,600 by 2020. The [2010 population estimates by age](#) show the following age demographic: 0-17 (20.9%), 18-64 (59.6%), and 65 and over (19.5%) (2010 Certified Estimate). Approximately 20% of Douglas County's population is between the ages of 4 and 20.

According to [U.S. Census Bureau, 2005-2009 American Community Survey](#), 93.4% of the county's population is white non-Hispanic, as compared to 86.2% statewide. Approximately 4.1% of Douglas County's population is Hispanic/Latino, followed by 1.4% American Indian, .9% Asian/Pacific Islander, and .3% African American.

### Income and Poverty

The national economic crisis continues to hit Douglas County hard, and the impact of the decline in the County's timber and wood products industries cannot be overstated. The effects of the decline reverberate throughout the community, particularly since there are few other jobs in the area with comparable pay and benefits for workers with relatively low education levels, unlike urban areas with more diversified economies.

According to the U.S. Census Bureau, 2005-2009 American Community Survey, 8.9% of Douglas County families are below the Federal Poverty Level (FPL), as compared to 9.2% statewide. Data compiled for the [2010 Children First for Oregon](#) show that 26% of children under age 18 in Douglas County live below the FPL poverty level, as compared to 19.6% statewide. Approximately 72% of public school children were eligible to receive free/reduced price lunches during the school year.

The economic difficulty faced by many Douglas County families is further reflected in local income and unemployment data. Data from the national [County Health Rankings](#) show an unemployment rate of 13.6% in Douglas County, as compared to 9.6% statewide. According to

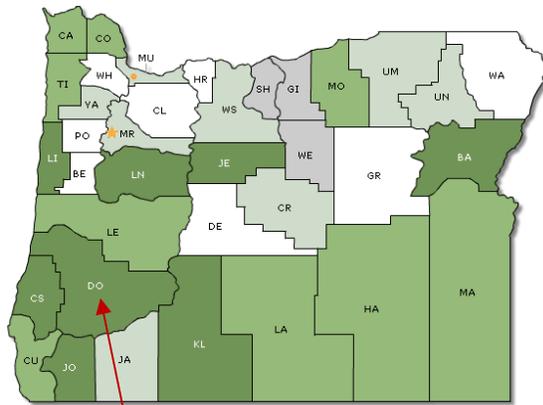
data compiled in the [2010 Children First for Oregon](#) report, the median family income is \$50,600 in Douglas County, 18% lower than the state median.

### County Health Rankings

The recently released [2011 County Health Rankings](#) report by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation provides a snapshot of counties throughout the U.S. on various health indicators. Researchers used a variety of measures to assess the level of overall health or **health outcomes**: the rate of people dying before age 75, self-reported fair or poor health, poor physical health days, poor mental health days, and the percent of births with low-birth weight. As compared to other counties in Oregon, Douglas County is ranked very low on overall health outcomes—a ranking of 31 out of 33.

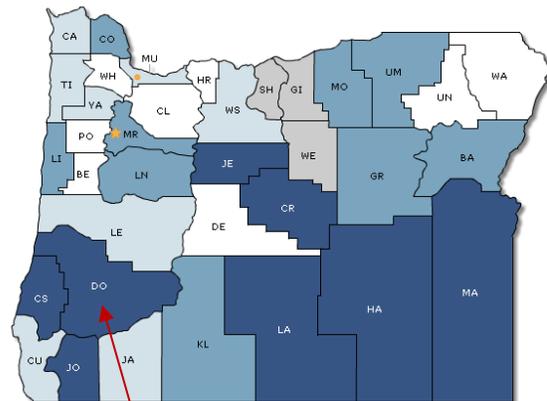
The overall **health factors** ranking is based on various factors that influence the health of communities, such as health behaviors (e.g., tobacco use, physical activity, obesity, teen pregnancy), clinical care (e.g., uninsured adults, access to health care providers, diabetic screening, social and economic factors (e.g., education, children in poverty, unemployment, income, crime), and the physical environment (e.g., air quality, access to healthy foods, liquor store density). Douglas County ranked 31 out of 33 on overall health factors.

2011 Health Outcomes



Baker (BA) - 29	Douglas (DO) - 31	Lake (LA) - 21	Sherman (SH) - NR
Benton (BE) - 1	Gilliam (GI) - NR	Lane (LE) - 18	Tillamook (TI) - 24
Clackamas (CL) - 4	Grant (GR) - 6	Lincoln (LI) - 27	Umatilla (UM) - 15
Clatsop (CA) - 17	Harney (HA) - 20	Linn (LN) - 28	Union (UN) - 11
Columbia (CO) - 19	Hood River (HR) - 2	Malheur (MA) - 23	Wallowa (WA) - 5
Coos (CS) - 26	Jackson (JA) - 13	Marion (MR) - 10	Wasco (WS) - 9
Crook (CR) - 14	Jefferson (JE) - 33	Morrow (MO) - 22	Washington (WH) - 3
Curry (CU) - 25	Josephine (JO) - 30	Multnomah (MU) - 16	Wheeler (WE) - NR
Deschutes (DE) - 7	Klamath (KL) - 32	Polk (PO) - 8	Yamhill (YA) - 12

2011 Health Factors



Baker (BA) - 18	Douglas (DO) - 31	Lake (LA) - 29	Sherman (SH) - NR
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## Tobacco Use

The prevalence of tobacco use among children and adults has declined dramatically in Oregon since the inception of the Tobacco Prevention & Education Program in 1996. Despite Oregon's success, however, tobacco use disparities still exist. Tobacco use remains high among people with low income, less education, and those who are uninsured or on Medicaid. American Indian/Alaska Native are more than twice as likely to smoke as adults in general, and suffer disproportionately from tobacco-related chronic disease.

The prevalence of tobacco use—smoking and smokeless tobacco—is higher, and often significantly higher, among children and adults in Douglas County than among children and adults statewide ([Oregon Tobacco Facts and Laws, 2011](#)).

- Adult cigarette smoking continues to be **significantly higher** in Douglas County (27.1%) than among adults statewide (17.1%).
- American Indian/Alaska Native in Oregon are **more than twice as likely** to smoke (38.3%) than adults statewide (17.1%).
- Cigarette smoking is **higher** among Douglas County 8th graders (12.5%) as compared to 8th graders statewide (8.8%).
- Cigarette smoking is **higher** among Douglas County 11th graders (20.1%) as compared to 11th graders statewide (16.5%).
- Smokeless tobacco use is **significantly higher** among Douglas County adults (14.7%) than among adults statewide (6.3%).
- Smokeless tobacco use is **significantly higher** among Douglas County 8th graders (9%) than among 8th graders statewide (5.3%).
- Tobacco use during pregnancy is **significantly higher** in Douglas County (24.6%) than statewide (12.2%). In other words, one in four infants is born to a woman who used tobacco while pregnant.

Economic status is the single greatest predictor of tobacco use in the United States and in Oregon. In Oregon, 13% of insured adults smoke, as compared to 33% adults who are uninsured, and 37% of adults who receive Medicaid/Oregon Health Plan. Data show that disparities in tobacco use are even higher in Douglas County, where an estimated 46% of people who receive Medicaid/Oregon Health Plan report tobacco use.

Douglas County's tobacco-related death rate (225 deaths per 100,000) is significantly higher than the statewide tobacco-related death rate (178 deaths per 100,000) (Oregon Tobacco Facts & Laws, 2011). The negative health effect of tobacco use is evidenced by the incidence and mortality of certain cancers. The most frequently diagnosed tobacco-related cancers are those of the lung and bronchus. The incidence of lung and bronchus cancer in the time period of 2002-2007 was significantly higher in Douglas County (75.9%) than statewide (67.9%). The incidence of all tobacco-related cancers is higher in Douglas County (153.9 per 100,000 population), as compared to the statewide rate (146.8 per 100,000 population).

In addition to the negative health effects, tobacco use imposes a significant economic burden on our economy. Tobacco use costs Oregon nearly \$2.4 billion dollars each year in direct medical costs and indirect costs of lost productivity due premature death. The annual cost to Douglas County alone is over \$115 million in direct medical costs and costs due to death and lost productivity.

**Physical Activity and Nutrition**

Nationally, obesity affects 17% of all children and adolescents – 3 times the rate from just one generation ago. Data compiled for the Oregon Health Improvement Plan show that obesity in Oregon adults has increased 121% since 1990, and jumped 54% among middle and high school students in the years between 2001 and 2009. Poor nutrition, physical inactivity, and obesity increase the risk of early onset diabetes and other preventable chronic diseases.

Overweight and obesity continue to be a problem in Douglas County. About 28% of children and teens in Douglas County are overweight, and over 60% of Douglas County adults are overweight or obese ([Oregon Health Improvement Plan, 2011-2020](#); [2006-2009 BRFSS County Level, Oregon Healthy Teens Survey, 2007-2008](#)).

<b>Overweight and Obesity in Douglas County</b>			
	8 <sup>th</sup> Grade	11 <sup>th</sup> Grade	Adults (18+ yrs)
Overweight	15%	14%	33.3%
Obese	12%	14%	28.1%

Many factors play a role in increased rates of overweight and obesity, including poor nutrition and physical inactivity. In Douglas County only 20.7% of 8<sup>th</sup> graders, 14.6% of 11<sup>th</sup> graders, and 26% of adults in Douglas County eats the recommended 5-a-day fruits and vegetables per day. Similarly, only 62% of 8<sup>th</sup> graders, 51% of 11<sup>th</sup> graders, and 57% of adults meets the recommended level of physical activity ([Oregon Healthy Teens Survey, 2007-2008](#)).

**Health Care Coverage**

The vast majority of communities in Douglas County are designated by the [Oregon Office of Rural Health](#) as areas of unmet healthcare need. According to the [2011 County Health Rankings](#) report, the ratio of population to primary healthcare providers in Douglas County is 1,301:1 population, as compared to the national benchmark of 631:1. Twenty-one percent (21%) of children under age 18 are living in poverty in Douglas County, as compared to compared to 18% statewide. Sixteen percent (16%) of adults are uninsured, as compared to the national benchmark of 13%. Data from the [Oregon Healthy Teen Survey, 2007-2008](#) shows that 79% of Douglas County 8<sup>th</sup> graders and 78.3% of 11<sup>th</sup> graders reported having an unmet physical health care need.

Safety net medical services are available in Douglas County through Umpqua Community Health Center (UCHC). UCHC is a Federally Qualified Health Center (FQHC) located in Roseburg, with satellite clinics in Glide, Drain, Myrtle Creek, and two School Based Health Centers. In 2007, the

FQHC became a delegate agency under the County’s Immunization Program, which opened up free vaccine to 317 eligible clients at the FQHC and opened up free vaccine to the underinsured VFC eligible clients seen at the county health department. At this time, the FQHC is providing immunizations at their Roseburg site, and in limited amounts at their satellite clinics. They have not implemented immunizations at the School Based Health Centers. During the last two years another Federally Qualified Look Alike Clinic has been added in the community of Winston, entitled South River Medical. This clinic provides family comprehensive health care by a physician, nurse practitioner and behavioral health counselor.

Douglas County has three hospitals within its borders; the Roseburg Veteran’s Affairs Medical Center, Mercy Medical Center, and Lower Umpqua Hospital.

**Chronic Disease**

Chronic diseases are the major causes of disability and death for Oregonians. The leading chronic disease in Douglas County continues to be cancer, followed by heart disease, cerebrovascular disease and chronic lower respiratory disease. According to the [2011 County Health Rankings](#) report, 22% of Douglas County adults report fair or poor health, as compared to 14% statewide. Data from the Oregon Health Authority show that the prevalence of many chronic conditions is significantly higher (\*) in Douglas County than statewide ([2006-2009 BRFSS County Level](#)).

<b>Age-Adjusted and Unadjusted Prevalence of Selected Chronic Conditions among Adults, by County, Oregon 2006-2009</b>						
	Stroke	Diabetes	Arthritis	Heart Attack	High BP	Asthma
Oregon	2.3%	6.8%	25.8%	3.5%	25.8%	9.7
Douglas	3.8%*	10.1%*	36.8%*	4.4%*	31.4%	12.7

Although tobacco-related cancers have declined in Oregon, Douglas County has a consistently higher incidence of tobacco-related cancer (lung and bronchial) than statewide. Mortality due to tobacco-related cancer is significantly higher in Douglas County than statewide. Data show approximately 225 deaths per 100,000 in Douglas County each year (27%), as compared to 178 per 100,000 statewide.

**Oral Health**

Oral health care is simply out of reach for many uninsured and underinsured children and adults in Douglas County. Consequently, many are at an increased risk for periodontal infection, tooth loss, and more serious health problems that result from or co-occur with dental disease. Most recent data available from the 2007 [Oregon Smile Survey](#) show that nearly two in three (64%) children in Oregon in first, second, and third grades have had a cavity, and 58% of children ages 1-4 have not received any Preventive Dental Care in the past year. In Douglas County, this number increases to about 79% by the time students reach the 8<sup>th</sup> grade ([Oregon Healthy Teen Survey, 2007-2008](#)).

Douglas County is designated by the [Health Resources & Services Administration](#) (HRSA) as a

dental health care shortage area. Community water fluoridation is one of the safest, least expensive, most effective and simplest ways to fight tooth decay. According to the Oregon Dental Association, only 20% of Oregonians drink fluoridated water. Douglas County does not have community water fluoridation. The Douglas County Public Health Division concurs with the Oregon Dental Association that “community water fluoridation has substantial lifelong decay prevention effects and is a highly cost-effective means of preventing tooth decay in the United States, regardless of socioeconomic status.”

Douglas County is one of four Oregon counties working in cooperation with the University of Washington Dental School on a Baby Smiles project to promote increased utilization of oral health care services by pregnant women and their children. To date, Douglas County has successfully enrolled 107 Medicaid eligible pregnant women in the Baby Smiles project and is following women and their infants through 9 months postpartum.

Douglas County residents benefit from dental services provided by Umpqua Community Health Center and the Umpqua Dental Society’s Donated Dental Days. The Douglas County WIC Program provides a dental education component to participants and the Mercy Foundation’s Healthy Kids Outreach Program provides screening, sealants and education to area school students. During this current fiscal year Public Health and Advantage Dental are working together to bring Flouride Varnish to WIC Classes.

### **Youth Development and Education**

Data from the [2010 Children First for Oregon](#) show that 83.7% of 3<sup>rd</sup> graders and 66.7% of 8<sup>th</sup> graders met or exceeded the state standards for reading. Approximately 91.9% of students complete high school. Approximately 86% of Douglas County residents 25 years of age and older are high school graduates, as compared to 88% statewide. Only 15% of Douglas County residents hold a Bachelor’s degree or higher, as compared to 28% statewide ([2010 U.S. Census for Douglas County](#)).

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Douglas County has three hospitals within its borders; the Roseburg Veteran’s Affairs Medical Center, Mercy Medical Center, and Lower Umpqua Hospital.

## Maternal and Child Health

Teen pregnancy rates in Douglas County are 6.9/1,000 births to teens ages 10-17 compared to statewide at 6.3 /1,000 births to teens ages 10-17 ([Oregon Teen Pregnancy Data](#), 2011 YTD), and 18.5 in Douglas County (15-17) compared to 16.1/1000 statewide. Other maternal and child health indicators of concern in Douglas County include the rate of low birth weight babies 2011 was YTD is 46.4/1,000 births, as compared to 60.4/1,000 births statewide ([Oregon Vital Statistics 2011](#)). One in four women (24.6%) in Douglas County report using tobacco during pregnancy, as compared to 12.2% statewide ([Oregon Tobacco Facts and Laws, 2011](#)).

	2006		2007		2008		2009		2010		2011- 9/2011	
	Oregon	Douglas	Oregon	Douglas								
Teen Preg. (10-17)	10.6	9.0	10.1	6.5	10.0	8.2	8.9	9.9	7.3	7.9	6.3	6.9
Teen Births %	2.8	3.0	2.6	3.4	2.8	3.3	2.6	3.5	2.1	9.5	NA	NA
1 <sup>st</sup> Tri. Care %	79.2	81.6	78.4	83.2	70.2	74.7	71.2	77.1	73.1	79.1	74.6	78.1
Adequate PNC%	93.8	95.1	93.6	94.2	93.0	94.5	93.8	96.6	94.5	96.5	94.8	95.1
Smoking Rate	12.3	25.7	11.7	24.0	14.0	30.6	13.4	29.8				
Birth Weight %	61.0	70.7	61.0	64.9	67.0	58.4	63.0	55.1	63.0	82.0	60.4	46.4
Marital Status	34.3	42.2	35.1	44.2	36.1	42.3	35.3	46.8	35.6	44.6	34.9	46.9
Infant Mortality	5.5	9.3	5.6	8.8	5.1	5.2	4.8	6.5	NA	NA	NA	NA
First Births	19,508	429	20,094	471	20,348	490	19,330	471	18,540	427	13,284	336

## Abuse and Neglect

Statewide, alcohol and drug issues represented the largest single family stress factor when child abuse/neglect was present. Data compiled for the [2010 Child Welfare Databook](#) report a victim rate of 16.4 per 1,000 children under age 18, as compared to 12.7 per 1,000 statewide, an increase of 4.1 percent over 2009 (12.2%). Threat of harm is the largest type of maltreatment incident statewide and in Douglas County, followed by incidents of neglect. The Foster Care rate per 1,000 children has remained at approximately 15% for the past two years, as compared to approximately 10% statewide.

## **Local Health Department Basic Services**

The mission of DCHSS is to assist residents and visitors in Douglas County to be healthy, independent, and safe. DCHSS administers and enforces state and local public health rules and laws, and works to promote policies, systems and environments that promote health and prevent disease and injury.

DCHSS provides the five basic services outlined in ORS 431.416 and related Administrative Rules. The basic services and functions are performed in a manner consistent with Minimum Standards for Local Health Departments, adopted by the Conference of Local Health Officials.

Inadequate funding to Public Health continues to jeopardize our ability to deliver services necessary to promote and protect public health. In fiscal year 2004-2005, the DCHSS Public Health Division had a budget that supported 64.7 FTE. In fiscal year 2008-2009, the Public Health Division will have an expected staffing of 49.8 FTE. In 2009-2010 the FTE decrease to 43.0. In Fiscal Year 2010/2011 the FTE will decreased to 41.1, and in Fiscal Year 2011/2012 will be reduced to 34.90 FTE's. With a reduction in staff comes a reduction in services, reduction in revenue, and a reduction in matching funds. Continued reductions will have a far-reaching impact on our ability to perform the functions of Public Health Programs and our ability to respond to Douglas County most pressing public health issues.

## **Adequacy of Core Services**

Oregon Administrative Rule 333-014-0050 establishes that each county and district health department shall perform (or cause to be performed) all of the duties and functions imposed upon it by Oregon Revised Statutes, and by official administrative rules adopted by the State Health Division and filed with the Secretary of State. These duties and functions shall be performed in a manner consistent with Minimum Standards for Local Health Departments, adopted by the Conference of Local Health Officials (CLHO). The following program areas shall be considered essential, and be specifically included in the overall annual plan of each county and district health department who shall assure programs are available.

### **1. Epidemiology and control of preventable diseases and disorders:**

It is difficult to sustain a minimally adequate response to epidemiology and control of preventable diseases when State funding has been reduced or is unpredictable, and County Public Health Programs rely on grant funding and County general fund dollars. In addition, DCHSS has been already impacted by budget cuts at the state level, with greater budget cuts expected in 2012-2013. DCHSS receives no State funding specific to control of Sexually Transmitted Diseases, only in-kind donations of medications. The State funding for Tuberculosis for 2010-2011 at \$4,021 does not fully fund the activities to investigate and manage the County's TB cases. In addition, HIV Prevention funding from the State is unpredictable with Oregon counties coming on or off the funding formula from year to year, making it difficult to plan for long term goals and sustainable activities. Due to the CDC's directive that HIV Prevention funding be directed to areas of the country with the highest HIV disease burden, DCHSS is expecting to be eliminated from the State HIV Prevention funding in fiscal year 2012-2013. For the fiscal year of 2011-2012, Douglas County received

\$30,425, so this funding loss will mean a cut to HIV Prevention programs. All of these reductions, impact the public health of the citizens of Douglas County.

The Board of Commissioners for three years in a row has directed that all Divisions in the Health Department that have county general fund support reduce the safety net dollars in the budget by 10%. For fiscal year 2011-2012, the instructions were to reduce the safety net dollars by another 35%. To frame the dollar reductions in a different picture, DCHSS budgeted the Communicable Disease, STD, TB, HIV, and Immunization Programs with 8.22 FTE in 09-10, 7.32 FTE in 10-11, and reduced to 5.42 FTE in the 11-12 budget. For Public Health to deal with epidemiology and control of preventable diseases, additional funding and staffing is required to adequately address public health priorities, reinstate Public Health programs, and meet national and state benchmarks.

**2. Parent and child health services, which includes family planning:**

Funding cuts to Public Health in the 2009-2010 budget mean the elimination of the Healthy Start Program (4.0 FTE's); 1- CHN3 position in support of the Prenatal Clinic; and 1 – CHN4, management position for Family Planning. In 2010-2011 the nursing workforce will again be reduced by another FTE. In 2011/2012 the nursing staff again will be reduced by 1.0 contracted out stationed nursing position at DHS and 2.0 FTE within the Field Staff Unit.

These cuts have a ripple effect on other programs. The reduction of a field staff nurse position not only means a struggle to meet Babies First! and Maternity Case Management program goals, but reduces our capacity to cover clinical services (e.g., immunizations, STD, HIV, Family Planning, or Communicable Disease).

**3. Collection and reporting of health statistics:**

Birth and death reporting, recording, and registration are provided by the DCHSS Roseburg office. In 2006, DCHSS implemented electronic death registration with funeral homes. Only one county physician participates in electronic death registration. DCHSS implemented electronic birth certificates in January 2008.

The Deputy Registrars at the Douglas County satellite Health Department offices (located in Canyonville, Drain and Reedsport) receive and send to the State applications for in-state and out-of-state birth certificate copies for clients of the Contraceptive Care (CCare) only. While the remote-located Deputy Registrars are able to notarize the application for birth certificate forms, employees neither process nor register the birth with the State of Oregon. Applications for birth certificate copies are: (a) accepted from CCare clients as part of the program eligibility requirements, (b) notarized if necessary, (c) sent to the State and, upon return from the applicable State (d) a copy of the birth certificate is forwarded to the applicant, if requested. The birth certificate copy is then reproduced by the Deputy Registrar and the copy is sent to the Medical Records department (with the electronic medical record number assigned) for inclusion in the CCare client's electronic medical record.

The following organization/staffing changes were implemented during the past year:

- a. The Douglas County Registrar position became vacant and a new Registrar was appointed effective 02/07/2011.

**4. Health information and referral services:**

DCHSS provides accurate and unbiased information and referral about local health and human services to the citizens of Douglas County. Information and referral is provided through response to telephone inquiries, providing information and referral information through news releases, presentations, printed materials, the County's website, community meetings and task groups, and by communicating in-person with DCHSS clients.

**5. Environmental health services:**

Environmental health resides as a program within Public Health. The programs focus has narrowed over the last several years to ensure that public facilities licensed under the authority granted to us by the Oregon Public Health Authority meet established standards of Public Health. The three primary components of this program are: licensed facilities, epidemiology, and public drinking water. We also provide technical consultation services to communities within the county that address a verity of environmental health issues. The licensed facilities and drinking water components of our program are fee or contract based and the epidemiological component (primarily rabies) is funded through pass through dollars from the State. In 2007-2008 the fee structure was changed for Benevolent Temporary Food Service Licenses. An evaluation of the Environmental Health fee structure has been completed and was found to be underfunded by approximately \$99,000. The Board of Commissioners has agreed to allow us to raise licensed facility fees for 2012. We are currently in the process of implementing the fee increase. Program fees are expected to continue to increase due to the expected loss of federal timber safety net dollars. The other two programs, epidemiology and drinking water underfunded by an additional \$16,305.

**Adequacy of Other Public Health Services**

The Douglas County Public Health Division has, in the past, provided a number of services of importance to the health of Douglas County, including health education and promotion, oral health promotion and outreach, older adult health education, and other important public health services. Continued budget cuts to the Public Health Division reduce our capacity to provide many of the programs and services that promote the health of our community. The following describes the other services provided under OAR 333-014-0050.

1. Emergency preparedness including participation in the development of Douglas County's emergency response plans and internal procedures necessary to carry out the local health department role in the plans.
  - a. Douglas County Public Health reviews plans written by the DCHSS Preparedness Coordinator to ensure coordination with Public Health resources and plans. Douglas

County Public Health employees are trained in ICS 100 and 700; staff is trained in higher level Incident Command courses as appropriate. Douglas County Public Health participates in countywide preparedness exercises. The Public Health Promotion Program Manager has received advanced training to fulfill the role of the local health department Public Information Officer. DCHSS has a great working relationship with the County Emergency Manager, Hospital Preparedness Program, local first responders, Veterans Hospital and other local government and private agencies that will likely respond to any all hazard disaster.

2. Laboratory services including providing diagnostic and screening tests to support public health services which are in compliance with quality assurance guidelines established by the State Health Division.
  - a. Douglas County Public Health has lab services that provide supportive services primarily to the Family Planning, WIC, and HIV/STD clinics. The lab certification and license was reduced to PPM in July 2011 from a moderate, high complexity Clinical Laboratory. During the 2011/2012 Fiscal Year the lab manager will retire and the Public Health Officer will become the lab manager. During this year, the division will send high complexity laboratory testing to outside labs.
3. Public Health Promotion includes activities and programs designed to address specific health risks and to promote policies, systems and environments that promote health.
  - a. Continued budget cuts to the Public Health Division have significantly reduced our capacity to conduct population based public health initiatives to advance policies, systems and environments that promote health and prevent disease. Community assessment and engagement efforts—essential elements of public health practice—are limited to the implementation of the Tobacco Prevention and Education grant program activities. In July 2010, Douglas County Public Health and Cow Creek Band of Umpqua Tribe of Indians partnered on a *Healthy Communities* assessment and planning project. Although funding for implementation of the Healthy Communities project was not available in FY 11/12, we continue to pursue partnerships and funding opportunities to sustain health promotion and chronic disease prevention efforts based community outreach to build and strengthen partnerships to support ongoing efforts, e.g., coordination of chronic disease self-management programs and services.
  - b. Over the past few years, budget reductions eliminated Douglas County's child passenger safety seat education and distribution program; senior health education; physical activity and nutrition activities; oral health promotion (except as related to the Baby Smiles Project); child injury prevention (excepts as related to Maternity Case Managements and Babies First); and many activities related to community health assessment, capacity building, and community mobilization.

- c. Basic client-based health education continues to be provided to individuals/families who receive services through various Public Health Division programs (e.g., Nurse Home Visit, WIC, and Family Planning).
- 4. Epidemiological investigation of deaths of public health significance with the county's medical examiner's office:
  - a. The medical examiner notifies the Public Health Division of deaths of public health significance.
- 5. Nutrition services including identification and intervention with client's at nutritional risk, and education and consultation for the promotion of good dietary habits:
  - a. Nutrition services are provided by the WIC Program. Nutritional assessment and education pieces are included within Maternity Case Management, Babies First!, Tuberculosis Program, HIV Case Management, CaCoon, Family Planning, and other Public Health programs.

The following areas listed in OAR 333-014-0050 will not be supported with staffing, planning, or resources in fiscal year 2012-2013: community-based dental health (except as related to the Baby Smiles research project), health education/health promotion (except as it relates to tobacco prevention), older adult health education, and primary health care services.

### **III. ACTION PLAN**

Action plans are included for:

1. Epidemiology and Control of Communicable Diseases
2. Emergency Preparedness
3. HIV
4. STD
5. Tuberculosis
6. Environmental Health
7. Safe Water
8. WIC
9. Family Planning
10. Perinatal Health
11. Child Health
12. Adolescent Health
13. Immunizations
14. Oral Health
15. Nutrition and Physical Activity
16. Substance Abuse-Tobacco Use
17. Child Injury Prevention

### III.1 Action Plan: Epidemiology & Control of Preventable Diseases

#### a. Current Condition

DCHSS is mandated by Oregon law to “use all reasonable means to investigate in a timely manner all reports of reportable diseases, infections, or conditions” (OAR 333-019-0000). With regard to public health emergency preparedness, Douglas County has taken steps to ensure timely detection, response, and efficiency in communicable disease reporting. State Support for Public Health dollars were doubled in 2007-2008, which awarded Douglas County \$121,000 versus the previous award of \$60,600. In fiscal year 2010-2011 Douglas County was awarded \$122,264, and in fiscal year 2011-2012 was awarded \$120,879, figures based on County population and not increased for inflation or the downturn in economy. The increased State Support for Public Health dollars is not even sufficient to fund two nurses and because local public health relies on state funding streams that have remained static over the years, or have even decreased or disappeared, the State Support for Public Health dollars have been spread to HIV, STD, TB, Communicable Disease, and Environmental Health programs in order to preserve public health functions. A separate funding stream, the federal funds for public health preparedness which started after September 11th, has helped our department to respond to communicable disease outbreaks, as well as support critical emergency response planning; however, these funds have also been decreasing, and since 2009, the Public Health Division in the Health Department did not receive a portion of this emergency response funding. A separate one-time funding stream, the federal funds for response to the 2009-2010 H1N1 outbreak, has helped our department’s critical response to pandemic influenza and improved our vaccine storage and handling equipment.

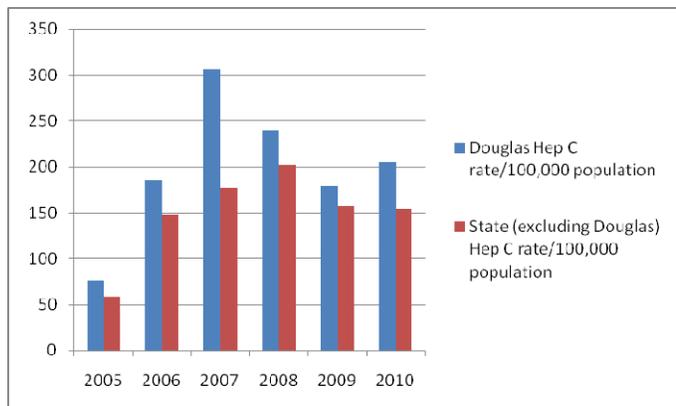
It is difficult to sustain a minimally adequate response to epidemiology and control of preventable diseases when State funding has been reduced or is unpredictable, and County Public Health Programs rely on grant funding and County general fund dollars. In our current staffing situation, there are little to no resources to offer community education opportunities e.g. health fairs.

In 2010, DCHSS investigated 695 cases of reportable diseases (includes reportable diseases, HIV/STD/TB cases and reportable influenza cases), compared to 509 cases in 2009. As of November 1<sup>st</sup>, 2011, DCHSS has already investigated 674 cases of reportable diseases. In addition, communicable disease control includes investigations of clusters or outbreaks of reportable diseases. In 2010, Douglas County investigated 8 outbreaks, most notably a restaurant associated Salmonella outbreak with 73 cases; a multi-county Salmonella outbreak associated with a local pasteurized milk distribution facility with 23 cases and a product recall; a multi-state raw cheese E. coli outbreak with product recall, an increased incidence of Meningococcal serotype C with 6 cases, and the 2009-2010 H1N1 Influenza Outbreak. In 2011, Douglas County has not had any reported outbreaks to investigate.

Douglas County has long standing membership on the CHLO-Epi Committee, with the current Douglas County representative a member since 2002. Although meetings are held in Salem, DCHSS staff attends by phone due to budget cuts.

In 2009, Douglas County became one of two counties to pilot and assist in the development of the new Oregon Public Health Epidemiology User System (Orpheus), a statewide communicable disease reporting database that now the entire state of Oregon has transitioned to. Orpheus has greatly improved the timeliness of communicable disease case reporting to DHS as most labs are electronically transmitted to this database. In 2011, Douglas County became one of five counties to pilot the development of the new Directory of Useful Databases for Epidemiologists (DUDE) which includes Orpheus, Outbreaks, GI Case Log, Sleuth, and other databases that can be added ad hoc during investigations.

Hepatitis C virus (HCV) is the most frequently reported communicable disease, other than Chlamydia. In 2010, Douglas County had 216 cases of chronic HCV newly reported. In 2010, Douglas County had 5 cases of acute HCV reported out of the 21 cases reported in Oregon. As of October 1<sup>st</sup>, 2011, Douglas County has had 181 cases of chronic HCV newly reported. Douglas County has



consistently higher rates of Hepatitis C than the average Oregon rates per 100,000 populations (see bar chart; note Hepatitis C first became reportable in July 2005). DCHSS mails information to each newly reported adult confirmed case of HCV to recommend Hepatitis A and Hepatitis B vaccination at low-cost through 317 Immunization funding. DCHSS partners with the local community based organization, Harm Reduction Center of Southern Oregon (HRC SO), to screen high risk persons for HCV. In 2007, DCHSS assisted HRC SO to begin using the Home Access HCV screening kit to screen high risk individuals, including needle exchange clients. Since 2006, DCHSS has participated in a free HCV screening project with DHS that targets high risk persons and collected epidemiological information about risk behaviors. Due to budget cuts at DCHSS and staff turnover at HRC SO, there has been very limited involvement in HCV screening outreach since 2009.

In year 2010, due to staffing cuts, DCHSS restructured the Communicable Disease Clinic services and merged them with Immunization and STD/HIV services. Therefore, now there is not a separate Communicable Disease clinic for TB refills, adult immunizations, post-vaccine screens, Hepatitis C screening, and head lice and scabies evaluations. This Communicable Disease Clinic previously in 2008 served 101 unduplicated clients in direct clinic services in Roseburg and satellite communicable disease clinics. DCHSS no longer provides head lice and scabies evaluations.

**b. Goals**

- a) To identify, prevent, & decrease endemic and emerging communicable and environmentally related diseases in Douglas County
- b) To target & vaccinate high-risk populations against vaccine-preventable diseases
- c) To improve public health preparedness
- d) To educate the public regarding communicable disease prevention, and
- e) To maintain and improve communicable disease reporting practices by local health care providers and laboratories
- f) To provide the ability to receive and respond to communicable disease reports and public health emergencies 24/7

**III.2 Action Plan: Emergency Preparedness**

**a. Current Condition:**

Three large earthquakes happened on the Ring of Fire. In Japan, 9.0 earthquake produced a tsunami that did damage to several coastal communities. The Reedsport area of Douglas County was fortunate to receive almost no damage from the tsunami. The Reedsport community did respond and evacuated one senior center and activated the opening of a shelter until the tsunami threat was canceled. The Douglas County EOC IC decided not to alert Public Health when the EOC was activated. This decision has been review and Public will be notified of future activations.

On March 31, 2011, a 71 mph wind storm that lasted less than thirty minutes and caused multiple power failures, downed trees, damaged houses and business throughout Douglas County. Fortunately no one was seriously injured. Douglas County has and will again be affected by major storms, wildfires, floods, and has the potential to be devastated by major earthquakes, tsunamis or pandemic flu. These disasters increase awareness of the need of all hazards planning and preparedness in the nation and the world. DCHSS must be prepared to identify and respond to bioterrorism as well as natural disasters, outbreaks of infectious diseases, and other threats to protect the health of our community. Improvements in public health preparedness have increased the functional capacity of day-to-day operations of DCHSS. DCHSS staff continue to work and exercise with local and state partners to refine procedures for responding to a broad range of disasters and emergencies.

Douglas County completed the two mini grant awards:

- Assessment, planning and exercise for a Federal Medical Station
- Purchase of materials for a Reedsport Emergency Medical Equipment Cache and backup health clinic

Public Health used PHER funds to acquire additional generators and refrigerators to upgrade vaccine storage in the rural clinics.

The DCHSS Coop Plan was reviewed and several improvements added to the document. The department continues to offer monthly First Aid/CPR/AED training for health department employees with the goal to have all employees trained in First Aid/CPR/AED. Existing CERT members and Therapeutic Children's Foster Parents have been allowed to take the departments First Aid/CPR/AED classes.

Some of the major preparedness projects for 2011 include:

- Assist in the development of the Umpqua Health Care Coalition to increase awareness and capacity in the medical community.
- Continue to improve the medical cache in Reedsport.
- Apply for and receive a grant to start a Medical Reserve Corp.

a. **Goals**

- a) To survive a disaster, this is likely to be a Cascadia subduction zone earthquake. Then be one of the first counties ready to receive and use the resources that will come.
- b) Increase the number of CERT train citizens by offering more classes per year and partnering with the Coos County CERT program.
- c) To enhance epidemiological surge capacity to respond to biological threats and disease outbreaks
- d) To continue the dissemination of accurate and timely information to the public, doctors, emergency responders, hospitals and other community partners through the Health Alert Network
- e) To integrate all hazards preparedness plans and procedures into the Douglas County Emergency Operations Plan

b. **Activities**

**Target Population: Douglas County**

- a) Using the new CDC proposed capability goals development and refinement Douglas County Health & Social Services emergency response capabilities for Strategic National Stockpile distribution, Mass Prophylaxis Plan, Chemical, Radiation, Health and Medical Annex, and All Hazards Plan.
- b) Maintain and enhance the emergency medical caches
- c) Continue to offer department staff communicable disease training to augment surge capacity abilities, NIMS, and risk communication skills.
- d) Continue participation in the CLHO-Epi Committee, Region 3 Healthcare Resources Services Administration Board, CHLO Public Health Preparedness Leadership Team, Emergency Management Advisory Group, and Public Information Officer Network
- e) Test and train on the county Health Alert Network system and Alert Oregon.
- f) Continue 24/7 staff response to public health emergencies
- g) Use ICS when dealing with large scale events

- h) Continue to plan and/or participate in public health preparedness training and exercises at the local, regional and state levels
- i) Continue public education campaigns about emerging diseases, e.g., West Nile Virus, Pandemic Influenza as needed
- j) Continue to meet with the Cow Creek Tribe for the development of a tribe emergency plan and a Mutual Aid Agreement
- k) Begin to incorporate special population organizations into emergency preparedness plans
- l) Continue to acquire and utilize the appropriate computer equipment, radios and wireless technology that meet the interoperable communications requirements of the County, State and Federal governments
- m) Assist U-Trans with the development and testing of their transportation security and emergency response plan
- n) Participate with the Roseburg Veterans Hospital, Mercy Medical Center and lower Umpqua Hospital exercises
- o) Participate in the Douglas County Disaster Recovery program.

**b. Evaluation**

- a) Review and update existing plans as needed and identified during exercises.
- b) Revise and update the Douglas County Health and Medical Annex E
- c) Documentation of DCHSS responder participation in state and local emergency management planning and training activities
- d) Documentation of health department staff participation in NIMS, public health and bioterrorism education
- e) Documentation of the transmission of CDC HAN alerts and advisories to healthcare providers, hospitals and emergency responders
- f) Compliance with the annual PE 12 Program Review conducted by the Oregon Department of Human Services
- g) Meet or exceed the contract requirements in the CERT grant.

### **III.3 Action Plan: HIV**

#### **a. Current Condition**

By Oregon law, physicians and laboratories are required to report HIV infection to the health department. Disease reporting enables public health follow-up, identify outbreaks, provides a better understanding of disease patterns, and may even save lives. This includes the following components: (i) investigations that report, monitor, and control diseases, (ii) lab testing and consultation, (iii) early detection, education, and prevention activities to reduce the disease and death rates of reportable communicable diseases, and (iv) collection and analysis of data for program planning. In 2010, DCHSS investigated 1 newly reported HIV case and in 2011 has investigated 2 newly reported HIV cases as of November 1<sup>st</sup>, all in collaboration with the state HIV Disease Intervention Specialist.

In fiscal year 2010-2011 Douglas County contracted with the Harm Reduction Center of Southern Oregon (HRC SO) to provide HIV Counseling and Testing (CTRS), Outreach to CTRS, Harm Reduction services, Social Networking Strategy, and Ryan White CARE Act services. In fiscal year 2011-2012 Douglas County extended its contract with HRC SO for Ryan White CARE Act services through November 2011, but because HRC SO has had staff turnover and is dissolving as an organization effective November 30, 2011, HRC SO chose to not contract for HIV Prevention services, but instead use up existing supplies and use volunteer staffing for HIV Prevention. Effective December 1<sup>st</sup>, 2011 DCHSS will be contracting with HIV Alliance for HIV Prevention services and the State will be contracting with HIV Alliance for Ryan White CARE Act services.

HIV Testing, Counseling, and Referral services are currently offered at the Roseburg health department site by appointment. From July through November 2011, HRC SO has also provided HIV CTRS. Services are also subcontracted to HIV Alliance effective December 1<sup>st</sup>, 2011 who provides HIV CTRS. All programs offer anonymous or confidential testing. From May 2010 through May 2011, DCHSS administered 141 HIV tests and HRC SO administered 215 HIV tests. Every year since 2008, fewer tests have been done at both sites annually, likely due to staffing turnover, program reductions at both facilities, and increased targeted testing. Of these tests done by DCHSS, 26% were to high risk populations of Men who have Sex with Men (MSM), IV Drug Users (IDU), MSM/IDU, or sex or needle partner is HIV positive, partner is at risk, or has sex for money/drugs/survival. Of these tests done by HRC SO, 85% were to these high risk populations. All programs utilize Rapid HIV testing.

Outreach services were subcontracted to HRC SO in fiscal year 2010-2011. Outreach will resume when HIV Alliance begins HIV Prevention work in Douglas County under subcontract. Services include the extending of HIV prevention services or activities beyond current or usual limits to meet high risk populations in their venues.

Harm Reduction services are subcontracted to HRC SO during 2010-2011 and have continued on a volunteer basis from July 2011 through November 2011. HIV Alliance will

continue harm reduction services beginning December 1, 2011. Services include education about harm reduction and prevention of HIV and other blood borne infections to community organizations such as homeless shelters, corrections facilities, drug treatment facilities and other venues that reach high risk individuals. Harm Reduction services include a syringe exchange program where in for example June 2011, 5200 syringes were turned in and 6100 syringes were given out. DCHSS and HRC SO both have drop-boxes for citizens to put sharps and syringes in 24/7/52. A syringe exchange program keeps syringes off streets, out of landfills, and prevents disease transmission. DCHSS and HRC SO participate in a project that targets persons with risk factors for HCV acquisition with free screening. The highest risk for HCV transmission is IV Drug Use, even if only one time injecting.

Social Network Strategy (SNS) services were subcontracted to HRC SO in fiscal year 2010-2011. HIV Alliance will resume SNS work December 1<sup>st</sup>, 2011. SNS is an intervention in which high risk persons are recruited to bring in their high risk associates for HIV testing. The recruiters and the associates receive financial incentive. Recruiters are typically either HIV/AIDS positive or are MSM who participate in high risk activities. In 2011, Douglas County became the first county to pilot and assist in the development of the new Social HIV Electronic Record (sHIVer), a statewide database for implementation of the SNS Program.

Condom distribution is recognized as a structural intervention with many benefits to public health. While it has long been an important component of HIV and STD prevention in Oregon, the State plans to further advance condom distribution in collaboration with community partners. The State plans to use its buying power to purchase a variety of condoms and lubricants at reduced prices and distribute them free to LHDs and other partners who request them. The State's goal is to have at least 400 condom distribution locations in 2012.

HRC SO and DCHSS coordinated the Ryan White Title II Case Management services for HIV positive persons. The Nurse Case Manager and HRC SO's Psychosocial Case Manager assist clients in accessing HIV medical care, thus reducing viral load and preventing HIV transmission. They also assist clients in accessing support services that include medical emergency financial assistance, psychosocial emergency financial assistance, housing services, linguistic services, medical transportation services, and oral health care. They also assist clients in accessing State Managed Services which include dental services, mental health, substance abuse treatment, home health, and medical nutritional services. In 2010, there were an estimated 67 HIV positive persons living in Douglas County. The Ryan White Case Management caseload in 2011 currently has 25 persons enrolled. Although MSM is the largest risk factor for HIV, about 30% of the Douglas County Ryan White caseload is female. DCHSS and HRC SO will no longer provide Ryan White HIV Case Management services effective December 1, 2011. These decisions were made in order to address funding challenges and enhance services in the community. As of December 1, 2011, the Oregon Health Authority is contracting with HIV Alliance to continue Ryan White services in Douglas County.

Douglas County has long-standing membership on the CHLO-HIV Committee since 2008. Although meetings are held in Portland, DCHSS staff attends by phone due to budget cuts. In 2010, Douglas County had membership on a funding formula subcommittee and also membership on a state group which modified the Harm Reduction and Outreach forms.

In 2009-2010, the DCHSS integrated STD and HIV Programs were budgeted for 1.66 FTE, in 2010-2011 for 0.96 FTE, and in 2011-2012 reduced to 0.81 FTE. With less funding and less staffing means a lesser ability to prevent HIV. The future of HIV Prevention Services for fiscal years involving 2012-2016 is uncertain at this time. In Oregon and across the country, HIV prevention is changing to align with national priorities. In June 2011, the Centers for Disease Control and Prevention (CDC) released a new HIV prevention funding opportunity announcement for state health departments. CDC's new approach to funding includes a national realignment of funds for core HIV prevention activities based on HIV/AIDS prevalence. This redistribution shifts funds from states and directly funded cities with a lower prevalence to those with a higher prevalence. As a jurisdiction with a relatively lower prevalence, Oregon's award will be reduced by 20% to 27% in 2012. Funding will continue to decrease each year through 2016. CDC's new approach focuses on prevention strategies that have demonstrated the greatest potential to reduce new infections and achieve the ambitious goals of the National HIV/AIDS Strategy. The strategies most emphasized are HIV testing, comprehensive prevention with positives, condom distribution, and policy/structural initiatives. Because CDC provides over 80% of the funds for HIV prevention in Oregon, prevention activities funded by OHA HIV Prevention Program must also change. Unfortunately, with decreased HIV prevention funds available, fewer counties will be funded. Funds will be distributed to local health departments (LHDs) based on a revised formula jointly agreed upon by the Conference of Local Health Officials and the Oregon Health Authority. The funding formula will continue to be based on HIV/AIDS cases reported by county. DCHSS is expecting to be eliminated from the funding formula in fiscal year 2012-2013. For the fiscal year of 2011-2012, Douglas County received \$30,425, so this funding loss will likely mean a cut to HIV Prevention programs; what HIV Prevention work and staffing may look like in fiscal year 2012-2013 is unknown at this time (November 2011). Any reductions will impact the public health of the citizens of Douglas County.

As it is likely that close to 500 persons living with HIV/AIDS (PLWHA) reside in counties that will not receive HIV prevention funding, the State HIV Prevention Program plans to implement a competitive solicitation process to provide comprehensive prevention with positives services in cross-county regions not funded through the funding formula. The specifics of this funding and what Douglas County may gain is not known at this time (November 2011).

The Douglas County and HIV Alliance HIV Prevention Program Plan is available on request that further outline goals and activities for 2011-2012.

**b. Goals (subject to change based on 2012-2013 budget outcomes)**

- a) To prevent the transmission of HIV infection in Douglas County
- b) To reduce AIDS and HIV case rates in Douglas County
- c) To provide support services to Persons Living with HIV or AIDS (PLWHA)
- d) To target and vaccinate high-risk populations against vaccine-preventable diseases
- e) To reduce barriers to HIV testing and counseling
- f) Continue use of rapid HIV testing
- g) To investigate cases of new HIV infection
- h) Programmatic stability with current budget forecast

**c. Activities (subject to change based on 2012-2013 budget outcomes)**

**Target population: PLWHA, Men who have sex with men, IV drug users, Hepatitis C population, persons at risk for HIV and other blood borne pathogens**

- a) HIV Counseling and Testing to high risk populations
- b) Conduct HIV disease investigation with newly reported positive HIV cases
- c) Integrate STD, HIV, and Hepatitis C prevention efforts
- d) Target and vaccinate high-risk populations against vaccine preventable diseases
- e) Limited communicable disease education in community settings, e.g., medical providers, health fairs, community agencies, and venues with target populations
- f) Referral to case management, early and sustained medical care, and partner notification for Persons Living with HIV/AIDS
- g) Complete activities as outlined in the 2011-2012 HIV Prevention Planning documents; HIV CTRS, HIV OHROCS, HIV Social Network Strategy, HIV Outreach
- h) Support HIV Alliance transition in doing HIV Prevention work in Douglas County
- i) Continue to work with State to improve the features of the Oregon Public Health Epi User System (Orpheus) in disease reporting

**d. Evaluation (subject to change based on 2012-2013 budget outcomes)**

- a) Number of HIV tests done at DCHSS and HIV Alliance, specifically Partners of PLWHA, MSM, MSM/IDU, and IDU populations
- b) Return rate for HIV results at DCHSS and HIV Alliance
- c) Number of condoms distributed at DCHSS and HIV Alliance
- d) Number of syringes exchanged at HIV Alliance
- e) Number of Hepatitis B and C testing done at DCHSS to high risk populations
- f) HIV/AIDS incidence and prevalence rates in Douglas County
- g) Number of Hepatitis A and B immunizations to high risk populations
- h) Number of MSM in Social Network Strategy that learn their HIV status for first time
- i) Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

### III.4 Action Plan: Sexually Transmitted Disease (STD)

#### a. Current Condition

Douglas County, as described in Divisions 17, 18 and 19 of OAR Chapter 333, bears the primary responsibility for identifying potential outbreaks of Sexually Transmitted Diseases (STDs), for preventing the incidence of STDs, and for reporting in a timely manner the incidence of Reportable STDs to the appropriate Department authorities. In addition, under contract with DHS, Douglas County may not deny STD clinical services to an individual seeking such services; must use all reasonable means to investigate in a timely manner all reports it receives of Reportable STDs in order to identify possible sources of infection and to carry out appropriate control measures; must offer STD cases and contacts, reported to or identified by DCHSS, evaluation and treatment; must provide staff time to examine, diagnose, and treat all individuals seeking examination, diagnosis or treatment for a Reportable STD; and must also perform, as resources permit, STD contact interview and partner notification services to individuals with Reportable STDs diagnosed by or reported to DCHSS. While resources may be limited it is expected that DCHSS will provide services to at least 20% of the individuals with Reportable STDs diagnosed by or reported to DCHSS.

DCHSS provides STD clinical services in the Roseburg office and also provides STD Case Management. In 2009-2010, the DCHSS integrated STD and HIV Programs were budgeted for 1.66 FTE, in 2010-2011 for 0.96 FTE, and as we approach 2011-2012 the budget will be reduced to 0.81 FTE. With less funding and less staffing means a lesser ability to do STD screening and case management as in past years. In 2009, STD/HIV clinic services were available four days a week. With budget cuts in 2010, clinic services were available by appointment three or fewer days a week. With less staffing, responsibilities for STD Case Management have been added to other staff's existing workloads.

DCHSS receives no state funding dollars to operate a STD Program. Douglas County does receive from the state 'In-Kind Resources' of antibiotics for treating STDs and receives at request Technical Assistance Resources of a Disease Intervention Specialist that is assigned to our region. As of March 2010, universal Chlamydia screening is no longer available in Public Health clinics due to state budget cuts; screening has been restricted to those at highest risk and those with Oregon Health Plan or CCARE coverage, otherwise costs are passed on to the client or screening is not done.

Chlamydia is the most frequently reported STD. Douglas County reported 257 cases of Chlamydia, 4 cases of Gonorrhea, and 1 case of early Syphilis in 2010. In comparison, Douglas County reported 186 cases of Chlamydia in 2009. In 2010, DCHSS diagnosed 115 cases (44% of the reported Chlamydia cases) in Douglas County through the DCHSS clinics. In comparison as of October 1, 2011, DCHSS diagnosed 83 cases (56% of the reported Chlamydia cases) in Douglas County through the DCHSS clinics. In 2010, DCHSS served 736 unduplicated clients in the STD and HIV Programs. As of October 1, 2011, DCHSS has served 481 unduplicated clients in the STD and HIV Programs this year. In 2010, DCHSS provided

1536 tests for Chlamydia & Gonorrhea and 168 tests for Syphilis. As of October 1, 2011, DCHSS has provided 909 tests for Chlamydia & Gonorrhea and 81 tests for Syphilis this year. In 2010, the STD clinic had a 13% positivity rate for the Chlamydia tests the clinic ordered. So far through June of 2011, the STD clinic has had a 13% positivity rate for the Chlamydia tests ordered. In 2010, the Adult Health clinic had a 3.8% positivity rate for Chlamydia tests the clinic ordered. So far through June of 2011, the Adult Health clinic has had a 5.35% positivity rate for the Chlamydia tests ordered.

Case rates for early Syphilis, Gonorrhea, and Chlamydia are all below state averages. The 2010 STD rates are available at the website link [Oregon STD Statistics](#).

#### **b. Goals**

- a) Prevent or minimize neonatal morbidity due to reportable bacterial STIs and conditions, including pelvic inflammatory disease and lymphogranuloma venereum
- b) Preserve fertility
- c) Diminish or prevent catastrophic consequences, such as stillbirths, congenital syphilis, miscarriages, chronic infection, and chronic pelvic pain due to STDs
- d) Reduce the prevalence of STDs
- e) Address STIs, including reportable, acute and chronic viral infections such as hepatitis A, B, and C, and HIV; and non-reportable chronic viral infections such as HPV, and HSV, as resources permit
- f) Reduce the reproductive number of an STD. Reducing the reproductive number of an STD requires at least one of the following occurs: 1) Shorten the average duration of infection. Methods include: early diagnosis and treatment, case investigation, follow-up and partner services, 2) Reduce the average probability of transmission per partner sexual contact. Methods include: condom use, fewer sex acts, and/or 3) Decrease the average number of sexual partners per unit of time. Methods include changing individual and community norms; encourage monogamy and serial monogamy; decrease number of concurrent partners
- g) Over 3% Chlamydia positivity in DCHSS clinics demonstrates effective screening
- h) Programmatic stability with current budget forecast

#### **c. Activities**

- a) Ensure a system for STD surveillance
- b) Ensure the evaluation and treatment of individuals with reportable, bacterial STDs, including PID (STD eval/treatment)
- c) Ensure that others at risk for infection (sex partners, associates, suspects, and clusters) are identified and offered evaluation and treatment (partner services)
- d) Continue to work with State to improve the features of the Oregon Public Health Epi User System (Orpheus) in disease reporting

#### **d. Evaluation**

- a) Chlamydia rates in Douglas County
- b) Gonorrhea rates in Douglas County
- c) Early syphilis rates in Douglas County
- d) Percent positivity of Chlamydia in DCHSS clinics
- e) STD clinic appointment show rates
- f) Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

### **III.5 Action Plan: Tuberculosis**

#### **a. Current Condition**

By Oregon law, physicians and laboratories are required to report Tuberculosis disease to the health department. Disease reporting enables appropriate public health follow-up, helps identify outbreaks, provides a better understanding of disease patterns, and may even save lives. Services include: investigating and monitoring treatment for each case and suspected case of active TB disease, ensuring adequate TB treatment, requiring appropriate medical examinations and laboratory testing to confirm the diagnosis of TB and response to therapy, coordinating care as needed, providing medication for the treatment of TB, monitoring and ensuring adherence to treatment guidelines, monitoring medication side effects, monitoring clinical response to treatment, performing contact investigations and following infected contacts through completion of treatment, identifying barriers to care and implementing strategies to remove those barriers. The TB services also include participation in quarterly cohort review, acceptance of Class B waivers and interjurisdictional transfers for evaluation and follow-up, and screening and management of Latent TB Infection.

Douglas County received \$4,021 in state funding dollars to operate a TB Program in fiscal year 2011-2012. Tuberculosis rates for the population of Douglas County remain stable with a low incidence rate. In 2010, the case rate was 1.9 diagnosed active TB cases reported to Douglas County per 100,000 population, while Oregon overall reported 2.3 cases per 100,000 population. In 2010, there were two confirmed cases of TB. There were also seven suspect cases of TB that took substantial staff time to case manage until the time that active TB was ruled out, one of which lived over an hour outside of Roseburg and required home visits as did not have a personal phone. In 2010, DCHSS spent 382 staff hours on Active TB Case Management. As of 10/01/2011, DCHSS has had zero confirmed cases of TB, but has spent 185.75 staff hours on Active TB Case Management due to time involving court ordered isolation of a TB case reported to Josephine County, and for time spent on suspect cases that were ruled out for TB.

DCHSS does Directly Observed Therapy (DOT) which involves providing TB drugs to the patient and watching as the patient swallows the medications over the entire course of treatment, which can be an approximate six to twelve months of treatment. Although a standard of care, the use of DOT places a financial burden on local health department resources. Douglas County has utilized video conferencing DOT to save staff time and travel resources when appropriate. Nursing staff complete annual fit testing for N95 masks as required.

The LPHA provides medications for persons diagnosed with latent TB, where the TB germ is dormant in the body, who cannot afford to pay for TB medications. In 2010, the LPHA provided medications for one person with latent TB. As of November 1, 2011, the LPHA provided medications for five people with latent TB. The LPHA referred persons with latent

TB that had insurance, or had the ability to pay, to their primary care provider for assessment and medications. In January 2010, Douglas County reorganized several clinics so treatment and monitoring for LTBI is now by appointment through the Communicable Disease nurse. Bi-weekly walk-in services for medications refills are no longer available.

Services provided include PPD screening. These services are available mostly in the Roseburg Immunization clinic where persons have the ability to return in 48 to 72 hours or as part of a TB contact investigation. In 2010, the LPHA administered and read 383 PPDs. As of October 1, 2011, the LPHA has administered and read 202 PPDs.

#### **b. Goals**

- a) To have early and accurate detection, diagnosis, and reporting of TB cases leading to initiation and completion of treatment
- b) To provide comprehensive case management to active TB cases, including Directly Observed Therapy
- c) To identify contacts of patients with infectious TB and treat those at risk with an effective drug regimen.
- d) Prevent transmission of TB
- e) Maintain or meet the 2015 National TB Priority Indicators and Program Objectives
  - (1) For patients with newly diagnosed TB for whom 12 months or less of treatment is indicated, 93.0% will complete treatment within 12 months.
  - (2) For TB patients with positive acid-fast bacillus (AFB) sputum-smear results, 100.0% (of patients) will be elicited for contacts.
  - (3) For contacts of sputum AFB smear-positive TB cases, 93.0% will be evaluated for infection and disease.
  - (4) For contacts of sputum AFB smear-positive TB cases with newly diagnosed latent TB infection (LTBI), 88.0% will start treatment.
  - (5) For contacts of sputum AFB smear-positive TB cases that have started treatment for newly diagnosed LTBI, 79.0% will complete treatment.
  - (6) For TB cases in patients ages 12 years or older with a pleural or respiratory site of disease, 95% will have a sputum culture result reported.
- f) To educate the health care providers and general public regarding tuberculosis
- g) As needed, to identify settings in which a high risk exists for transmission of Mycobacterium tuberculosis and apply effective infection-control measures
- h) Programmatic stability with current budget forecast

#### **c. Activities**

**Target population: Active Tuberculosis cases first priority, close contacts of Active Tuberculosis cases second priority, LTBI infection third priority**

- a) Assess the extent and characteristics of TB in the jurisdiction through collection and analysis of epidemiologic data

- b) Develop policies and procedures and a plan for controlling TB
- c) Assure diagnostic, clinical, and preventive services needed to implement the plan for controlling TB
- d) Provide information and education to policy makers, health-care professionals, and the public regarding control of TB in the jurisdiction
- e) Train public health staff in communicable disease control, including N95 fit testing of identified staff
- f) Offer Tuberculosis medication refills, and monitoring for side effects for eligible clients
- g) Continue to work with State to improve the features of the Oregon Public Health Epi User System (Orpheus) in disease reporting

**d. Evaluation**

- a) Staff will report increased knowledge of tuberculosis and tuberculosis case management.
- b) The tuberculosis case rate will remain stable or decrease in Douglas County
- c) Evaluation of the 2015 National TB Priority Indicators and Program Objectives on the Douglas County and Oregon levels
- d) Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

### III.6 Action Plan: Environmental Health

#### a. Current Condition

Environmental factors have a great impact on the health of the community and quality of life. DCHSS works to establish and maintain a broad based approach to environmental health service delivery. Efforts are focused upon the influence and impact of environmental factors, both natural and manmade, and the management and control of these factors so as to prevent and control illnesses, in order to promote health. Local environmental health services are required by ORS 431.416 with specific standards performed or programs availability assured as authorized by OAR Chapter 333-014-00050.

Services in Environmental Health include state-mandated health inspections, licensing & plan review of restaurants, public pools & tourist facilities, certification of food handlers, food borne illness disease investigations, oversight of public drinking water systems, West Nile Virus surveillance and education, environmental health education, disaster response, and animal bite investigations. In fiscal year 2010-2011, 2200 inspections were conducted at the various licensed facilities and institutions, with 5,475 violations noted. The general public reported 1 complaint, with 0 reporting a food-borne illness but all failed to meet case definition requirements, and 0 food-borne illness outbreak investigations were done.

In 2011 a re-evaluation of the Environmental Health fee structure was made, and the program was found to be underfunded. As a result of these findings the County has decided to support the raising of our fees. The fees are to be raised in a three step process over three consecutive years. The first step increase is to to be implemented in January of 2011.

The Douglas County Public Works Department manages and operates an effective solid waste disposal and recycling program. At the twelve free-of-charge county transfer sites and one central landfill, the environment is protected and public health hazard's reduced or eliminated. Private solid waste franchises provide adequate collection and disposal services. In the face of reduced County General Funding, the discussions are still taking place about imposing a fee structure for businesses or for citizens utilizing the landfill.

The Environmental Health Program participates on the Douglas County Solid Waste Advisory Committee.

The County Planning Department has taken over all program responsibilities of on-site wastewater management.

The Department of Agriculture performs all program responsibilities of shellfish sanitation. The Environmental Health Program collaborates with the Department of Agriculture when a recreational shellfish harvest closure is considered, when "Red Tide", "Domoic Acid", or sewage contamination affects shellfish digging areas. Through the food facility inspection

program, restaurants that serve shellfish are monitored to assure shellfish products are from licensed and approved sources. The required identification tags are to be collected and maintained by the food facility.

**a. Goals**

The Environmental Health Program shall be vigilant in its continuous and ongoing efforts to reduce or eliminate environmental health risk factors that have the capacity to cause human suffering, disease, or injuries.

**b. Activities**

**Target population: Douglas County**

- a) Inspection, licensure, consultation and complaint investigation of food services, tourist facilities, institutions, public spas and swimming pools, drinking water systems, to assure conformance with public health standards
- b) Environmental Health assessment and planning
- c) Food handler training is now offered on-line and in a classroom to all food service workers. The instruction provides food service workers with current methods of storing, preparing, and serving food to the public.
- d) Information and referral services to the public and governmental agencies.
- e) Investigation of community health hazards, reported animal bites, and diseases that potentially are relate to food or water or environmental causes
- f) Liaison with local emergency response planning agencies, oversight of Bioterrorism, Chemical, Radiation, and Health & Medical annexes of the County Disaster Response Plan
- g) Conduct West Nile Virus surveillance and provide public education
- h) Lead poisoning investigation and counseling

**c. Evaluation**

- a) The number of violations identified in food service establishments.
- b) Review state wide trends associated with environmental diseases and compare them to what is happening in Douglas County.
- c) Track trends in violations.
- d) The number of complaints received concerning licenses facilities.
- e) The number of Food borne Illness (FBI) complaints received.
- f) The number of FBI outbreaks reported and investigated.
- g) Maintain inspection frequencies of at least 90% in the number of food service facilities, tourist facilities, school and public facilities food service operations, public spas and pools, shelters and correctional facilities.
- h) Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services.

- i) Monitor reported animal bites and resolutions

### **III.7 Action Plan: Safe Water**

#### **a. Current Condition**

Every community is faced with the threat that domestic water supplies may become contaminated and gives rise to communicable disease transmission and/or objectionable taste or odor problems. Should the improper disposal or spill of hazardous materials occur in surface waters, associated drinking water supplies would become at risk. Inadequate drinking water systems and/or substandard waste water treatment are factors which potentate the transmission of water-borne illnesses. Annually, approximately 18 public water systems are surveyed on site to assure proper construction and operation. Water lab test results, required to be completed routinely by the water system operator, are monitored for levels of chemical contaminants and any existence of indicator microorganisms.

#### **b. Goals**

- a) To advise the general public of water-borne contaminants that may produce health risks from drinking, irrigating, swimming or wading
- b) To follow-up on all disease outbreaks and emergencies including spills that occur in Douglas County
- c) To complete all of the grant assurances including surveys, alerts, ERP reviews, and targeting system with more than 11 violation points.
- d) 91% of the county population, served by public water systems, will receive water that meets all applicable health based drinking water standards throughout the year.

#### **c. Activities**

##### **Target population: Douglas County**

- a) Provide technical and compliance assistance to all operators of public drinking water systems when these systems are found to be in violation of public health requirements and safe water quality standards
- b) Investigate every incident of hazardous chemical spill or contamination; maintain membership in Oregon Emergency Response System (OERS)
- c) Annual review and update of the Douglas County written plan for responding to emergencies that involve public water systems
- d) Provide printed and verbal information regarding the development of safe water supplies to people using onsite water wells and springs as requested.
- e) Disseminate advisories when high levels of e-coli or other bacteria or contact contaminants are discovered in naturally occurring rivers and streams.
- f) Provide the public with information concerning the health affects of blue/green algae.

**d. Evaluation**

- a) Number of monitoring and reporting violations identified with public water systems.
- b) Number of MCL monitoring violations identified of public water systems
- c) Number of Public Water Systems with more than 11 violation points
- d) All public water systems are provided with consultation and technical guidance when found in violation of safe water quality standards or who fail to monitor
- e) At least 18 sanitary surveys completed annually
- f) Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

### **III.8 Action Plan: Women, Infant, Child (WIC)**

Program Plan for 2012 2013 and evaluation of 2011-2012 will be completed and submitted when direction and guidance has been received from the State WIC Program.

### **III.9 Action Plan: Family Planning**

#### **a. Current Condition**

The Douglas County Family Planning Clinic continues to offer contraceptive and reproductive health counseling, initial and annual reproductive health exams, screening tests and/or treatment for sexually transmitted diseases, and a variety of available birth control methods through the main Roseburg clinic and three outlying clinics. The clinics provide appointment visits as well as drop-in clinics. There are drop-in clinics for contraceptive counseling four days per week in Roseburg, and one day per week in the outlying offices. 93.7% of the clients are below 150% of the FPL with only 3.1% having third party insurance. Only 81.9% of the clients qualify for FPEP or OHP coverage. These health department services have resulted in averting 475 pregnancies, and serving over 2,592 (39.8%) women in need (DHS/ALHERS data, 2011).

With cuts that occurred in the 2010-2011 Public Health budget, another 0.5 FTE nursing position was eliminated. In the past, it has been difficult to recruit and hire nurse practitioner staff for the Family Planning Clinic. With decreased nursing capacity, we have decreased the availability of appointment times for initial, annual exams and drop in clinics for contraceptive management.

Information is provided to all clients about primary care providers and community health centers in the area to help meet those health care needs that are not provided in our clinic.

#### **b. Goals**

- a) To improve and maintain the health status of women and men in Douglas County by providing reproductive health care services and to assure that all residents have access to voluntary and effective family planning methods.
- b) Assure continued high quality clinical family planning and related preventive health services to improve overall individual and community health.
- c) Reduce risk of unintended pregnancy.

#### **c. Activities**

**Target population: Persons of reproductive age, especially of low-income, in Douglas County**

- a) Ensure adequate follow-up for abnormal pap smears through pap tracking system.
- b) Ensure adequate screening for Chlamydia following the Region X infertility Prevention Project screening guidelines.
- c) Evaluate monthly no-show rates by site.
- d) Continue to conduct semi-annual client satisfaction surveys.

- e) Continue to provide appropriate and available methods for birth control.
- f) Maintain continuing education opportunities for professional and support staff activities.
- g) Continue reproductive health exam, contraceptive counseling visits, and education in Roseburg and all outlying offices.

**d. Evaluation**

- a) Review of AHLERS Data
- b) Monthly chart audits
- c) Review of data from internal IS system
- d) Review of data service elements for group participations.
- e) Review of data from internal system in tracking presentations.
- f) Review AHLERS data for number pregnancies averted, percentage of women in need being served, and the number of teens being served.

### III.10 Action Plan: Perinatal Health

#### Current Condition

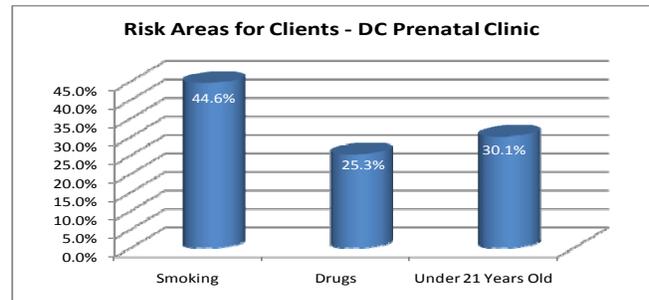
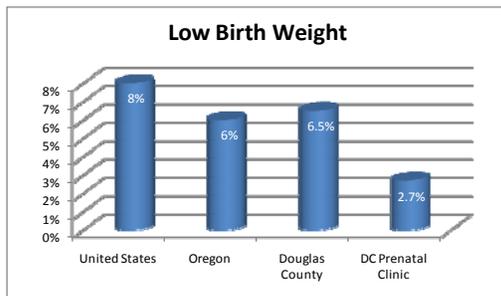
In July 2009 the Prenatal Care Clinic transitioned operations from a solely supported by the county to a cooperative support of DCIPA, UCHC, and Douglas County. This has resulted in the Prenatal Clinic Coordinator becoming an employee of DCIPA and maintaining the clinic at the county at a location that clients are familiar and feel safe in coming too. The Prenatal Clinic has provided prenatal care for 100 pregnant females a year in a community where the number of physicians providing prenatal care in Douglas County has decreased over the last several years; the Reedsport area of the county has no prenatal care provider.

The adequate prenatal care rate has continued to be stable in the 95% range. With the stabilization of the prenatal clinic funding it is noticed that the entry into first trimester care has improved to 85.6%. (HCCSO Data ).

Douglas County currently has Public Health Nurses that provide Maternity Case Management (MCM) home visits to their assigned geographic area. The complexity of services needed has increased tremendously with the difficult issues of alcohol, drugs, mental health and violence. These continue to be ongoing challenges as we strive for healthy pregnancies. The MCM Program has implemented mandatory education concerning fetal alcohol, other drug and tobacco exposure, breastfeeding promotion, intimate partner violence, maternal/fetal HIV and Hepatitis B transmission, maternal oral health, nutrition/healthy weight/physical activity, perinatal mood disorders, and prematurity and pre-term birth risks. In the next year, Douglas County will begin looking at funding opportunities for staff training in order to implement the Nurse Family Partnership program.

DCHSS has Public Health Nurses that provide Maternity Case Management home visits to their assigned geographic area. Two of these positions are funded through a federal grant for "Eliminating Disparities" and reducing infant mortality in targeted zip codes and the Hispanic population. As part of the federal grant, women are also being screened for maternal depression using the PHQ-9. Women are screened once prenatally and once postpartum. The next phase of the project will look to build linkages and partnerships between public health and mental health services. We have already begun the first steps of integration between public health and mental health. We will be imbedding a mental health worker in the home visit system to help improve access to mental health services. We are also looking at implementation of a peer support group for women in our community. Douglas County also has established a local contact with Postpartum Support International. Alcohol, drugs, mental health and violence increase the complexity of needed services. These continue to be ongoing challenges as we strive for a healthy baby. 85.7% of the maternity case management caseload receive early prenatal care. (HCCSO Data).

In 2010, the department conducted an internal review and evaluation of pregnant woman in the prenatal clinic, reviewing risk factors and resulting outcomes.



Given the strong correlation between smoking and/or drug use and LBW babies, it would be expected that a population with the highest usages in the nation would experience a higher prevalence of LBW deliveries. But they didn't. Instead, their rate was much lower. There is plausible qualitative information regarding "what works" at the DC PNC which provides insights into the incongruent relationship between their clients' risk level and the rate of LBW deliveries.

Briefly, the DC PNC is made possible through a partnership among Douglas County, the Douglas County Individual Practice Association (DCIPA), Mercy Medical Center who provide personnel, laboratory testing, radiology and staff time and obstetricians with Integrated Women's Health Care. Other providers offer treatment / counseling services for women at the PNC and include Douglas County Maternity Case Management and Women Infant and Children, substance abuse treatment at Adapt, Battered Persons Advocacy, Douglas County Mental Health, Food Pantries, and local churches.

This team provides a "wraparound" approach to high risk clients. It includes intensive, individualized case management. Clients initially meet with a registered nurse (RN) for an intake assessment. Unlike the brief assessment done in many clinical settings, this is a one to two hour process where staff get to know each woman's health history, current stresses in their lives, available support, etc. Then an individualized plan is developed which builds on client strengths to address risk areas in their lives. The plan is based on service needs and instead of referring clients out to a variety of support services, those services come together to meet the client's needs under a coordinated treatment plan. This includes providers from physical health, mental health, alcohol and drug treatment, etc. working together to coordinate case care and provide services. The approach is client-based. Women at the clinic report that they feel "safe" at the DC PNC because the staff provide "non-judgmental" care.

In the 2011 legislative system, HB 3650 was passed to further the work to transform Health Care in the State of Oregon. Currently, in Douglas County, a local leadership group including a County Commissioner, Health Administrator, CEO's of Mercy Medical Center, DCIPA and Adapt have been meeting to prepare Douglas County for Coordinated Care in Douglas

County. Also, within the last quarter the medical director of DCPIA, the Public Health Director, MCH Manager and Prenatal Clinic Coordinator have been meeting to explore further opportunities to serve pregnant woman in Douglas County.

At this time for fiscal year 2011-2012, we did a reduction in field nurse positions. Recruitment continues to be a challenge for nursing positions due to lack of a competitive wage and lack of Bachelor Degree prepared nurses in the community. The reduction of a field nurse position not only means a struggle to meet Maternity Case Management program goals, but also means reduced capacity to meet clinic demands, e.g., Immunizations, STD, HIV, Family Planning, or Communicable Disease.

The Public Health Division is working in to reduce the rate of tobacco use among pregnant women by including tobacco use screening and counseling as part of all clinic and home visit encounters. Home visit nurses are trained to use the 5As--an evidence-based five-step smoking cessation counseling method to increase smoking cessation among the women they serve. In 2008, Douglas County Public Health received a \$10,000 grant from the March of Dimes-Greater Oregon Chapter for a one year Baby & Me Tobacco-Free project to address maternal smoking in Douglas County. Although the original grant period has ended, we have continued the project through the Maternity Case Management and Prenatal Clinic programs. Data from the program show Baby & Me to be successful in helping women to quit smoking during pregnancy and to stay quit after the birth of their baby. We have enrolled 74 women in the program. The quit rate for participants in the program is about fifty percent.

In 2008, the Douglas County Perinatal Task Force was formed to address the problem of tobacco, drug, and alcohol use among pregnant women, lack of adequate prenatal care and to improve prenatal outcomes for the women of Douglas County. In April 2009, Douglas County Public Health began implementation of the SART system. The SART system consists of Screening, Assessing, Referring, and Treatment for pregnant and potentially pregnant women for drug and alcohol use.

The SART system was developed by the Children's Research Triangle in Chicago, Illinois. Douglas County was chosen as one of the sites to implement this program. In June 2009, SART was expanded to include all of the area OBGYN practices. The goal is that all pregnant women in Douglas County will be universally screened for drug and alcohol use, and will receive appropriate referrals and treatment. Currently there are 3 of our 4 local OBGYN providers in addition to the Douglas County Prenatal Clinic that have been trained and are participating in screening women using the SART system.

Public Health is one of four counties (Douglas, Josephine, Lincoln, Jefferson) participating in the Baby Smiles Project to increase utilization of dental health benefits for Medicaid eligible pregnant women and to reduce early childhood dental caries. The project, which is being implemented in cooperation with the University of Washington and Klamath County, has enrolled 107 pregnant women to participate through 9 months post partum. The Baby Smile project is supported by a .60 FTE Baby Smiles Coordinator.

Douglas County has continued to participate in the Oregon Mothers Care Program. With the Public Health Division as an Oregon Mothers Care site, we hope to increase the number of women receiving first trimester prenatal care by being a liaison for them with OHP and other needed services during their pregnancy (e.g., WIC, prenatal care provider, home visiting services).

**a. Goals**

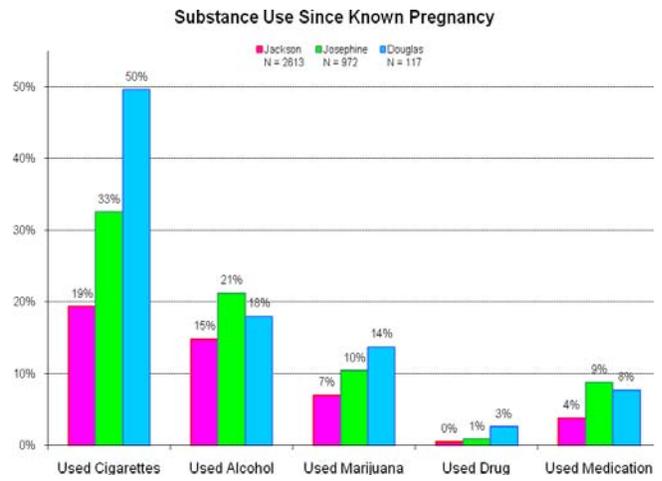
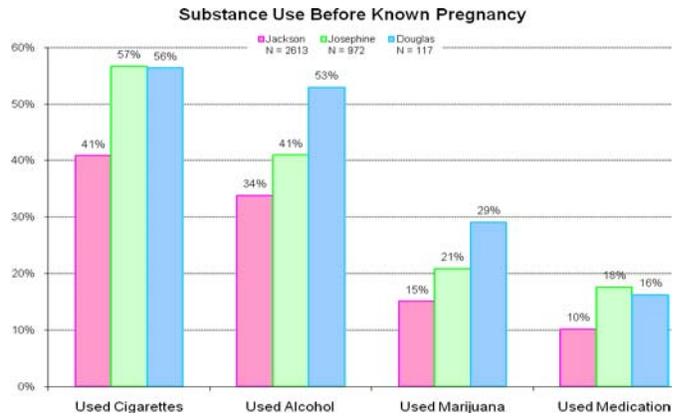
The Maternity Case Management Program provides an expansion of perinatal services to include management of health, social, economic, and nutritional factors. The purpose is to reduce the incidence of low birth weight infants and other poor pregnancy outcomes.

**b. Activities**

**Target population: Pregnant women, especially of low-income, in Douglas County**

- a) Pre-conception counseling
- b) Pregnancy and Parenting Education
- c) Referral to Community Resources, e.g., WIC, Maternity Case Management, Family Planning
- d) Continuation of Baby Smiles Oral Health Project
- e) Continuation of Baby & Me Tobacco-Free
- f) Integration of services between Public Health and Mental Health

**c. Evaluation**



- a) Percent of pregnant women who access prenatal care in their first trimester
- b) Infant mortality rate per year
- c) Infant low birth-weight rate per year
- d) Percent of women who smoke during pregnancy
- e) Number of pregnant women who agree to Maternity Case Management home visiting Program
- f) Teen pregnancy rate per year
- g) Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services
- h) Number of women who quit smoking during pregnancy and who stay quit at 3 and 6 months after the birth of their babies.
- i) Successful participation in evaluation protocol of Baby Smiles Oral Health Project as determined by the University of Washington.

### **III.11 Action Plan: Child Health**

#### **a. Current Condition**

DCHSS has Public Health Nurses that provide Babies First!/ Targeted Case Management, and CaCoon home visits to their assigned geographic area. Two of these positions are funded through a federal grant for “Eliminating Disparities” and reducing infant mortality in targeted zip codes. Alcohol, drugs, mental health and violence increase the complexity of needed services. These continue to be ongoing challenges as we strive for a healthy baby. The Public Health Division participates in the Douglas County Multi-Disciplinary Child Abuse Team and the Douglas County Child Fatality Review Team. These teams work to decrease child abuse and mortality. The Public Health Division also participates in the Child Abuse Prevention Coalition which was formed as part of a grant received by our local hospital. In the next year, Douglas County will look at funding opportunities for training in order to work towards implementation of the Nurse Family Partnership home visit program.

The field staff position were reduced by 2.0 FTE’s in the 2011/2012 fiscal year. There have been challenges in filling nurse vacancies due to our inability to offer a competitive wage. The reduction of a field nurse position not only means a struggle to meet Home Visit Program goals, but also means reduced capacity to meet clinic demands, e.g., Immunizations, STD, HIV, Family Planning, and Communicable Disease.

DCHSS provides a Public Health Nurse under contract with the local ESD to provide nurse delegation for special needs children within the school environment. This same nurse provides home care coordination for children with special health care needs through the state CaCoon program. A public health representative sits on the Early Intervention Council.

The local Commission on Children and Families and the Healthy Start Advisory Board made the decision to transition the Healthy Start Program to a private non-profit agency in October 2008. Douglas County Public Health continues to work collaboratively with the Healthy Start program to meet the complex health and social service needs of children and families. The Public Health Division Director is represented on the Douglas County Early Childhood Planning Coalition and the Healthy Start Advisory Board.

During 2011, with legislative approval of SB 909, forming the Early Childhood Learning Council, Douglas County has been working collaboratively with the Douglas County Commission on Children and Families. A task group of Douglas County Early Childhood Planning Coalition has been developing potential model for Douglas County Early Childhood systems and how identification, services, and referral could occur in response to this new legislation. Through the next 6 months, much will continue to be developed and tried in order to meet the legislative goals of having all children ready for kindergarten.

#### **b. Goals**

- a) Improve the physical, developmental, and emotional health of high risk infants
- b) Improve the early identification of infants and young children at risk of developmental delay and/or other health/medical related issues
- c) Assist families to identify and access the appropriate community resources that meet their child's specific needs
- d) Standardize a public health nurse's ability to: assess child development and health issues affecting young children, use screening tools appropriately, and make community resources available for referral
- e) Health outcomes will be collected and analyzed yearly
- f) Reduce child abuse and neglect rates
- g) Reduce infant mortality
- h) Improve the percent of 2-year-olds who are adequately immunized
- i) Promote and improve the overall health status of parents and children in Douglas County through preventive health programs and services
- j) Increase access to preventive and ongoing health care
- k) Identify basic health and developmental needs in children throughout Douglas County from birth through age five
- l) Increase children's school readiness by early identification of developmental milestones
- m) Promote positive parent-child interactions, parent education and support, and referrals to community partners

**c. Activities**

**Target population: High-risk infants and children, ages birth to four years in Douglas County**

Key activities include outreach, home visits, health assessment and developmental screening, growth monitoring, case management, parenting education, information and referral, health education, and advocacy. All infants receiving home visits through the Babies First! Program will be screened and assessed based on the Babies First! Program manual. All children found to have abnormal screening will be referred for intervention. All families will be assessed for case management needs. All Public Health Nurses will receive Babies First! orientation and ongoing education in infant growth and development, child health issues, child medical concerns, and appropriate screening and assessment tools.

- a) Education, screening and follow up, counseling, referral, or health services for family planning, perinatal care, infants, and children
- b) Screening and physical exams that evaluate developmental achievements, growth parameters, immunization status, hearing & vision acuities, speech and language development, and provide ongoing education, information and referral
- c) Provide and coordinate varied programs to meet parent and child needs in Douglas County; WIC Program, Immunization Clinic services, Family Planning services,

- Maternity Case Management, Targeted Case Management through the Babies First Program, and CaCoon Coordination
- d) Continue participation in the Douglas County Multi-Disciplinary Child Abuse Team, Douglas County Early Childhood Planning Coalition, and Douglas County Child Fatality Review Team

**d. Evaluation**

- a) Percent of all newborns in Oregon referred to the Babies First! program for screening, assessment, and follow-up
- b) Percent of infants and children who experience normal growth and development patterns by 12 month screening
- c) Percent of 2-year-olds who are adequately immunized
- d) Percent of 2-year-olds who have normal dental screenings
- e) Percent of 2-year-olds who demonstrate normal hearing and vision
- f) Post-neonatal mortality rate per year
- g) Child abuse and neglect rates per year
- h) Low birth weight rate per year
- i) Infant mortality rate per year
- j) Percent of mothers breastfeeding at six months and at 12 months
- k) Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

### **III.12 Action Plan: Adolescent Health**

#### **a. Current Condition**

Due to budget cuts, DCHSS closed its primary care Child Health clinic in July 2007. Children needing medical care are now referred to their primary care provider or the local Federally Qualified Health Center.

With the implementation of Oregon's revised comprehensive sexuality education law on July 1, 2009 (ORS 336.455) and the concurrent elimination of funding to Oregon's STARS Program, Douglas County Public Health no longer serves as a lead for the coordination of the school-based adolescent sexual health (abstinence-only) education. These changes, along with continued budget cuts to the Public Health Division, have resulted in the discontinuation of Douglas County's Healthy Teens Coalition – a local community network that worked to raise awareness about teen pregnancy and sexually transmitted diseases, and to promote healthy choices, refusal skills, and adolescent sexual health.

DCHSS subcontracts with Umpqua Community Health Center, the local FQHC, to provide a School Based Health Center at Roseburg High School and at Douglas High School in the Winston-Dillard School District.

#### **b. Goals**

- a) Promote and improve the overall health status of children and adolescents in Douglas County through preventive health programs and services

#### **c. Activities**

**Target population: Students of Roseburg High School and Douglas High**

- a) Manage contract with FQHC to provide School Based health Center Services in Roseburg and Winston-Dillard school districts.

#### **d. Evaluation**

- a) Monitor Oregon child and adolescent health data
- b) Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

### **III.13 Action Plan: Immunizations**

#### **a. Current Condition**

Oregon Administrative Rule 333-014-0050 establishes control of reportable communicable disease is a core public health function required by law. Control of disease includes assuring the availability of immunizations for human and animal target populations in the community.

DCHSS operates immunization clinics in Roseburg, Canyonville, Drain, Reedsport, and off-site locations. Services include the federal Vaccine for Children's (VFC) Program which helps families of children who may not otherwise have access to vaccines by providing free vaccines. VFC Program eligibility includes children 18 years old or younger who have Medicaid, are uninsured, are Native American or Alaskan native, or if their insurance doesn't cover one or all vaccines. In 2010 DCHSS administered 5621 shots under the VFC program. The LPHA is unique in the community as it also participates in the Section 317 Program which helps children and adults who may not otherwise have access to vaccines by providing free vaccines. The 317 Program eligibility includes persons who are 18 years old or younger and cannot afford their insurance co-pay or deductible; or is a child or adult at risk for disease as outlined by the Oregon Immunization Program. In 2010 the LPHA administered 1268 shots under the 317 program. In FY 2010 the LPHA administered 9751 shots overall. A free 4-hour Shots for Tots clinic is held annually on a Saturday in February; in 2011 it served 162 children. From January 2010 through October 2011, the LPHA participated in an HPV Special Project and were able to administer 620 doses of HPV vaccine to women ages 19-26 years of age that otherwise would not have received HPV vaccine due to the high cost of the vaccine.

The LPHA does an annual Flu/Pneumonia campaign; flu shots are given to the home bound and flu clinics are held in areas of the county outside the Roseburg area. In 2009, DCHSS ended offering a flu clinic in the Roseburg area, reduced the number of flu shots provided in the home, and reduced the number of employers served in the flu campaign. These reductions were due to staffing cuts and due to the Roseburg area having greater access to physicians and pharmacies offering vaccine. Since then, we have also continued to see a decreased demand for flu vaccine overall, likely due to DCHSS not being a preferred provider for insurance and not accepting private insurance except in limited situations when a client is insured under Medicaid. DCHSS has provided 1,315 doses of flu vaccine for the 2010-2011 season. As of October 26, 2011, DCHSS has provided 853 doses of flu vaccine for the 2011-2012 season. In 2009, DCHSS coordinated the ordering and distribution of H1N1 influenza vaccine so that 16,804 doses of vaccine were administered to protect the County population. Unlike some counties, DCHSS has not provided school located influenza vaccine clinics; this has been in attempt to best utilize staffing to offer clinics that serve ages across the lifetime.

DCHSS uses the online Oregon ALERT registry that houses vaccination records and in 2010 the DCHSS staff used the web search and forecasting feature of ALERT over 19,000 times. In 2011, DCHSS was awarded grant funding to improve their electronic health record system to be able to submit data real-time to the ALERT registry; this project is ongoing. In conjunction, the statewide ALERT registry system has merged with IRIS, the immunization records system that most local public health departments use, to create the new ALERT IIS. This new registry collects immunization data from both public and private health care providers to create complete records for individuals in Oregon. ALERT IIS is said to offer more functionality for users, including a comprehensive web-based user interface and more flexibility for bidirectional exchange of data with Electronic Health Records (EHRs). Timely submission of immunization data to a registry, or real-time transmission, helps provide consolidated immunization records for new and existing patients, reduces staff time searching for a patient immunization record, helps to prevent missed opportunities or over-immunization, and helps to reduce the spread of vaccine preventable diseases by facilitating the provision of timely immunizations. DCHSS staff has been trained on the ALERT IIS and we are nearing transition to an improved EHR.

A variety of evaluation is conducted by the Oregon Immunization Program to help us focus on the goal to protect Oregonians from vaccine-preventable diseases. The 2010 annual AFIX report shows that only 69% of 2 year olds seen at DCHSS were up-to-date on immunizations, compared to 73% of Oregon 2 year olds. This is in part due to only 57% of 2 year olds having their 4<sup>th</sup> DTaP, compared to the 2010 Oregon LHD average of 70%. The population based immunization rates (PBRs) reflect immunization rates for 2 year olds compiled from records submitted to ALERT from all County immunization providers, not just exclusive of DCHSS. The 2010 PBRs (4:3:1:3:3:1) show 77.8% of Douglas County 2 year olds are up-to-date on immunizations versus 72.9% of Oregon 2 year olds. This is the best PBR rate ever in Douglas County and is an increase of 16.2% since 2009.

Management of vaccines includes: ordering vaccines; controlling inventory; storing vaccines & monitoring conditions; minimization of vaccine wastage; proper vaccine stock rotation; vaccine receiving, packing, and transporting; and emergency planning. The health department utilizes redundant temperature monitoring, including temperature tracking availability in an online system. In 2010, DCHSS installed back-up generators at the Drain and Reedsport locations, purchased new separate lab grade refrigerator and freezer units for all locations, and purchased portable refrigerator/freezer units for off-site use. In 2011, DCHSS installed a back-up generator at the Canyonville location, purchased additional portable refrigerator/freezer units for off-site use, and set up monitoring of network systems at Drain, Canyonville and Reedsport locations to assist with monitoring statuses of alarms.

Umpqua Community Health Center (UCHC) continues as a delegate agency of DCHSS. This includes their main site, satellite offices. They do not provide immunizations at the two School Based Health Centers that they operate. The unique contract relationship between any health department and a delegate agency that is a FQHC is that it affords the delegate

access to 317 vaccines and affords the health department access to use the code F vaccine eligibility code. Code F eligibility is for any child 18 and younger that is underinsured, meaning one or more vaccines is not covered by their insurance plan. This contract relationship expands the availability of vaccines to vulnerable populations in the County. UCHC's vaccine practices are reviewed by the health department every 2 years. In early 2011 UCHC was found out of compliance with submission of adult immunization data to ALERT, UCHC was given 45 days to bring their clinics into compliance, of which they did. Otherwise, the State Immunization Program and DCHSS found UCHC in compliance during their May 2011 delegate agency review. In 2011, Douglas County Public Health passed through to UCHC \$6,599 worth of new vaccine storage and handling equipment to safeguard immunizations at their sites.

DCHSS administers vaccines for international travelers by appointment in Roseburg. In 2010, DCHSS served 128 County residents that planned international travel. As of November 1, 2011, DCHSS has served 73 County residents planning international travel so far this year. In addition, the clinic is a certified Yellow Fever vaccine center. According to International Health Regulations, yellow fever vaccine must be administered at certified yellow fever vaccination centers. There is no other certified Yellow Fever vaccine center in Douglas County.

Perinatal Hepatitis B virus transmission can be prevented by identifying Hepatitis B infected pregnant women and providing Hepatitis B immune globulin and Hepatitis B vaccine to the infants within 12 hours of birth. Preventing perinatal transmission is an integral part of the national strategy to eliminate Hepatitis B in the United States. National guidelines call for the following: universal screening of pregnant women for HBsAg during each pregnancy; case management of HBsAg-positive mothers and their infants; provision of immunoprophylaxis for infants born to infected mothers, including Hepatitis B vaccine and Hepatitis B immune globulin; and routine vaccination of all infants with the Hepatitis B vaccine series, with the first dose administered at birth. Services in the Perinatal Hepatitis B Prevention Program include case management of 1-3 mother/child pairs a year.

Client reminder and recall interventions involve reminding members of a target population that vaccinations are due (reminders) or late (recall). Client reminder and recall interventions are recommended based on strong evidence of effectiveness in improving vaccination coverage: (1) in children and adults; (2) in a range of settings and populations; (3) when applied at different levels of scale—from individual practice settings to entire communities; (4) across a range of intervention characteristics (e.g., reminder or recall, content, theoretical basis and method of delivery); and (5) whether used alone or with additional components. DCHSS sends a reminder to each client seen previously to remind them of upcoming immunizations. DCHSS also does targeted recalls to populations seen at risk as needed; e.g. in 2010 when there was an increased incidence of bacterial meningitis cases a recall was sent to over 7,000 adolescents past due on meningococcal vaccine; when confirmed Hepatitis C virus infection, recall is sent for Hep A and Hep B vaccine; when new school law requirements are initiated, recall is sent to specific ages to encourage

vaccination prior to the annual school law exclusion dates. With the new ALERT IIS, Douglas County has started doing recalls at 5 months of age and 16 months of age for vaccines past due, and at 13 months of age for vaccines due now.

DCHSS shall comply with the Oregon School Immunization Law. Services include ongoing consultation with certified childcare facilities, preschools, Head Start facilities; and all schools in Douglas County. In 2010, this was 104 facilities. In 2011, this will be 115 facilities. One could surmise that more facilities, specifically preschools and certified daycares, have opened up as a response to the downturn in the economy and families are looking for self-employment opportunities. Annually all school files are reviewed by school Administrators, turned into DCHSS for second review and DCHSS issues letters to parents when children are not complete with their immunizations, or do not have an immunization record on file at the school. In 2011, DCHSS issued 912 letters to parents/guardians; 232 children were not in compliance by the 2 week deadline and therefore excluded from school until in compliance. Annually, the State Immunization Program and the DCHSS do targeted on-site visits for a minimum of four facilities to monitor facility compliance with School Law. In August 2010, DCHSS held clinics at four middle schools to offer adolescent immunizations during back-to-school registration; in total 215 adolescents were vaccinated. In August 2011, DCHSS held clinics at four middle schools to offer adolescent immunizations during back-to-school registration; in total 106 adolescents were vaccinated. One could surmise that DCHSS saw less attendance at the school clinics in 2011 for any of the following potential reasons suggested: schools did not advertise the clinics well; siblings were turned away due to less staffing; DCHSS stopped accepting private insurance for billing in 2010 and more families realize this now; and/or adolescents are being better immunized in their medical home or are more responsive to ongoing immunization reminder/recalls sent by DCHSS.

A representative of DCHSS has had membership on the Oregon Immunization Policy Advisory Team (IPAT) since 2007. IPAT advises the Oregon Public Health Immunization Program on the development, prioritization and implementation of immunization policy issues. Composed of voting members who are experts in immunization and/or policy fields and non-voting members from the Department of Human Services, IPAT strives to facilitate a sound, collaborative decision-making process around immunization issues facing Oregonians. DCHSS represents the voice of local health departments in Oregon. Other members represent insurance plans, schools, family physicians and pediatric groups, policy & research, County health officers, school nurses, pharmacies, and more. Although all meetings are held in Portland, DCHSS staff attends by phone due to budget cuts.

See the attached Immunization Annual Plan for compliance.

**b. Goals**

- a) To identify, prevent, & decrease vaccine-preventable diseases
- b) To target & vaccinate high-risk populations against vaccine-preventable diseases

- c) To improve public health preparedness
- d) To educate the public regarding vaccine-preventable diseases
- e) To maintain or improve immunization rates across the lifetime
- f) To submit immunization data to ALERT IIS in nearly real-time, after QA processes
- g) To have no vaccine loss due to mishandling
- h) To prevent perinatal transmission of Hepatitis B
- i) To comply with Oregon School Immunization law

**c. Activities**

**Target population: Douglas County**

- a) Provide epidemiologic investigations to report, monitor, and control communicable disease and other health hazard
- b) Programmatic stability with current budget forecast
- c) Provide immunization clinics that include eligibility for free vaccines through VFC or 317 funding, or special project vaccine
- d) Provide flu/pneumonia clinics
- e) Transition to ALERT IIS
- f) Continue contract with delegate agency
- g) Case management of perinatal Hepatitis B mothers
- h) Provide reminder/recalls on immunizations
- i) Maintain vaccine accountability system
- j) Implement Oregon School Immunization law

**d. Evaluation**

- a) Vaccine preventable diseases rates
- b) AFIX immunization rates
- c) Population based immunization rates
- d) Timeliness rates of immunization data submitted to ALERT IIS
- e) Results of biennial review of delegate agency; due fall 2011
- f) Rates of reportable communicable vaccine preventable disease
- g) Number of incomplete and no record letters mailed for school law exclusion process
- h) Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

### **III.14 Action Plan: Oral Health**

#### **a. Current Condition**

Douglas County is one of four Oregon counties working in cooperation with the University of Washington Dental School and Klamath County on a Baby Smiles Project to study the effect of an educational intervention on the utilization of oral health care services by pregnant women and their children. To date, Douglas County has successfully enrolled 107 Medicaid eligible pregnant women in the Baby Smiles project and is following those women and their infants through 9 months postpartum. The Baby Smiles Project is being implemented in close cooperation with the WIC and Oregon Mothers Care programs. The Baby Smiles Project is anticipated to continue through May 2013.

Budget cuts to the Public Health Division have eliminated our capacity to pursue opportunities and partnerships for oral health screening, education, or urgent care for uninsured or under insured children and adults. The following oral health services are no longer provided by our Public Health Promotion Program: community engagement activities, population-based oral health education, grant writing for school or community-based dental health screening or direct care.

Dental services provided by Umpqua Community Health Center and the Umpqua Dental Society's Donated Dental Days have helped to fill the gap in dental care to underserved, rural children and adults in Douglas County. The Douglas County WIC Program provides a dental education component to participants and the Mercy Foundation's Healthy Kids Outreach Program provides screening, sealants and education to area school students.

#### **b. Goals**

- a) To provide dental education and referral within the scope and capacity of Public Health Division programs.

#### **c. Activities**

##### **Target population: Pregnant and parenting women and children**

- a) Implement Baby Smiles Project in cooperation with University of Washington and Klamath County. See III.9 Perinatal Health section for information about Baby Smiles oral health project.
- b) Implement WIC 2011/2012 WIC Nutrition Education Plan, WIC Staff Training Plan, and Evaluation of 2010/2011 WIC Nutrition Education Plan.

### III.15 Action Plan: Nutrition and Physical Activity

#### a. Current Condition

Oregon’s rural communities, as compared to urban, often have higher rates of poor nutrition and physical inactivity, and as a consequence, higher rates of chronic disease and preventable death. In Douglas County, only 20.7% of 8<sup>th</sup> graders, 14.6% of 11<sup>th</sup> graders, and 26% of adults in Douglas County reported eating the recommended fruits and vegetables per day. Similarly, only 62% of 8<sup>th</sup> graders, 51% of 11<sup>th</sup> graders, and 57% of adults meets the recommended level of physical activity.

Data show that obesity continues to be a problem in Douglas County, with rates that are consistently higher than the statewide rates ([Oregon Health Improvement Plan, 2011-2020](#), [Oregon Healthy Teens Survey, 2007-2008](#)).

<b>Overweight and Obesity in Douglas County</b>			
	8 <sup>th</sup> Grade	11 <sup>th</sup> Grade	Adults (18+ yrs)
Overweight	15%	14%	33.3%
Obese	12%	14%	28.1%

In coordination with our Tobacco Prevention & Education best-practice objective to “Build Capacity for Chronic Disease Prevention, Early Detection, and Self-Management,” we are able to support local efforts to address the leading risk factors for chronic disease, including poor nutrition and physical inactivity. Our Public Health Promotion Program facilitates LiveWell Douglas County—a community alliance that is working to advance policies, systems and environments that promote healthy community conditions and lifestyles.

In FY 11/12, Douglas County Public Health worked in cooperation with the Cow Creek Band of Umpqua Tribe of Indians to conduct a county-wide Healthy Communities capacity building assessment. The assessment guided development of [Pathways to Healthy Communities](#)—a community action plan for improving policy, systems, and environments to support healthy lifestyles. Pathways to Healthy Communities will provide background and direction for future partnerships and funding opportunities.

Nutrition education is an essential component of the Douglas County WIC Program, Nurse Home Visiting Program, and the Prenatal Clinic service delivery to pregnant and parenting women and their families.

#### a. Goals

- a) To provide nutrition education within the scope and capacity of Public Health Division programs.

- b) To pursue partnerships and funding opportunities to support population-based health promotion and chronic disease prevention efforts as they relate to the leading risk factors for chronic disease, including poor nutrition and physical inactivity.

**d. Activities**

**Target populations: See Activities section**

- a) See Tobacco Prevention & Education workplan for 2011-2012 and 2012-2013.
- b) See workplans for III.10 Perinatal Health, III.11 Child Health, and III.12 Adolescent health.
- c) See the current 2011/2012 WIC Nutrition Education Plan, WIC Staff Training Plan, and Evaluation of 2010/2011 WIC Nutrition Education Plan.

**a. Evaluation**

- a) See Tobacco Prevention & Education workplan for 2011-2012 and 2012-2013.
- b) Number of women who quit smoking during pregnancy and who stay quit at 3 and 6 months after the birth of their babies. See workplan for III.10 Perinatal Health.
- c) See the attached 2011/2012 WIC Nutrition Education Plan, WIC Staff Training Plan, and Evaluation of 2010/2011 WIC Nutrition Education Plan.

### **III.16 Action Plan: Tobacco Prevention & Education**

#### **a. Current Condition**

Tobacco is the leading cause of preventable death in Oregon. While tobacco use continues to decline in Oregon, use is consistently higher in Douglas County than statewide. Every year in Douglas County, over 300 people die from tobacco use (a rate of 225 per 100,000 or 27% of all deaths) and over 6,400 suffer from a tobacco-related illness. Adult smoking is significantly higher in Douglas County (27.1%) than among adults statewide (17.1%) ([Oregon Tobacco Facts & Laws, 2011](#)). Although tobacco use among Douglas County youth is higher than among youth statewide, we are encouraged by a reported decrease in use among 8<sup>th</sup> graders (15.1% in 2006 to 12.5% in 2008) and 11<sup>th</sup> graders (21.7% in 2006 to 20.1% in 2008) ([Oregon Healthy Teen Survey, 2007-2008](#)).

Tobacco use among pregnant women in Douglas County continues at an alarmingly high rate. The most recent data show that one in four infants (24.6%) are born to women who report using tobacco during pregnancy, as compared to 12.2% statewide ([Oregon Tobacco Facts & Laws, 2011](#)). Tobacco costs Douglas County residents over \$115 million per year in direct medical costs and indirect costs of lost productivity due to tobacco-related death.

Health risk screening and counseling are important elements of all clinics and home visit encounters. Douglas County Public Health Division programs include tobacco prevention education in coordination with all of its client and community-based programs and services. The Prenatal Clinic Care, Family Planning, Maternity Case Management, Babies First, and WIC Programs all serve as important touch points for client education about the risks of tobacco use. See Action Plan III.9 Perinatal Health for information about reducing tobacco use during pregnancy.

#### **b. Goals**

Community-based tobacco prevention and education is a central component of Oregon's comprehensive tobacco control program, and is essential to fulfilling Oregon's mission to advance policies, systems and environments that promote health and prevent disease.

Douglas County's Tobacco Prevention & Education Program goals are:

- a) Create tobacco-free environments to reduce secondhand smoke exposure
- b) Prevent tobacco initiation among youth and young adults
- c) Promote quitting among youth and adults
- d) Identify and eliminate disparities in tobacco use and tobacco-related chronic disease

#### **c. Activities**

**Target population: Douglas County; pregnant and parenting women**

The Tobacco Prevention & Education consists of multiple best practice objectives, each designed to ensure community collaboration, ongoing assessment, education and outreach, media advocacy, policy development and implementation, and promotion of the Oregon Tobacco Quit Line. Current best practice objectives include:

- a) Build Capacity for Chronic Disease Prevention, Early Detection, and Self-Management
- b) Advance healthy, tobacco-free worksite policies
- c) Enforce the Indoor Clean Air Act
- d) Promote adoption of smokefree housing policies
- e) Support healthy, tobacco-free community college policies
- f) Promote tobacco-free outdoor venues, e.g., parks, fairgrounds
- g) Provide tobacco prevention education within the scope and capacity of Public Health Division Programs. See III.10 Action Plan for Perinatal Health.
- h) Represent Public Health on local, regional and statewide tobacco and other drug prevention committees and coalitions
- i) Grantwriting and sustainability planning to support healthy communities efforts

**d. Evaluation**

- a) Monitor local data on alcohol, tobacco, and other drug abuse in Douglas County, e.g., Oregon Healthy Teen Survey, Student Wellness Survey, Behavioral Risk Factor Surveillance System, Oregon Tobacco Facts & Laws, County Healthy Rankings, Oregon Benchmark reports and other available data sources.
- b) Quarterly reports and program evaluation as required by Oregon Tobacco Prevention & Education Program guidelines and contact agreement with the Oregon Health Authority.

### **III.17 Action Plan: Child Injury Prevention**

#### **a. Current Condition**

Injury is the fourth leading cause of death in Oregon, and the leading cause of death among Oregonians 1 to 44 years of age ([Oregon Injury Epidemiology Program](#)). Each year, more than 2,000 Oregonians die as a result of injury, and nearly 20,000 are hospitalized as a direct result of injuries. According to a 2008 report compiled by the Oregon Department of Human Services, Injury Prevention & Epidemiology Program, the leading causes of unintentional injury to Douglas County children residents are: motor vehicle traffic-related injuries, falls, and poisoning.

As a result of continued budget cuts, Douglas County Public Health has discontinued population-based child injury prevention programs, including child passenger safety seat education and distribution for low income families, bike helmet safety education, suicide prevention and other community-based injury prevention initiatives or campaigns. Child injury prevention education (e.g., crib safety, fall prevention, home safety, poisoning and burn prevention) continues to be an important element of Public Health Division Maternity Case Management and Babies First! programs, and the Douglas County Sheriff's Office provides child safety seat education as part of its community outreach.

Data compiled for the [2010 Child Welfare Databook](#) report a victim rate of 16.4 per 1,000 children under age 18, as compared to 12.7 per 1,000 statewide. Statewide, alcohol and drug issues represented the largest single family stress factor when child abuse/neglect was present. In accordance with [ORS 714.747](#), the Douglas County Public Health Division is part of the local interagency Child Fatality Review Team (CFRT) to review child deaths that are "unexpected," including deaths from unintentional injuries, intentional injuries (homicide and suicide), SIDS and unexpected deaths due to natural causes. The Mercy Foundation, in coordination with the Douglas County Violence Prevention Coalition, is working to implement a child abuse prevention and intervention strategy in Douglas County.

#### **b. Goals**

- a) To help reduce child injury through education and outreach to families served by the Douglas County Maternity Case Management and Babies First! programs.
- b) To identify circumstances with public health significance leading to child fatality.
- c) To ensure public health perspective in agency response and identification of the cause and manner of child fatalities.

#### **c. Activities**

**Target population: Douglas County**

- a) Promote child injury prevention through Public Health Division programs, e.g., Nurse Home Visit, Babies First!
- b) Participate in local Child Fatality Review Team review meetings

**d. Evaluation**

- a) Number of families receiving injury prevention education about safe sleeping, child passenger safety seats, home safety, and other child injury prevention information as measured by number of home visits per year.
- b) Number of child fatality review meetings attended
- c) Number of child fatalities reviewed

### **III.18 Action Plan: Health Statistics**

#### **a. Current Condition**

Birth and death reporting, recording, and registration are provided by the DCHSS Roseburg office. In 2006, DCHSS implemented electronic death registration with funeral homes. Only one county physician participates in electronic death registration. DCHSS implemented electronic birth certificates in January 2008.

Assessment of mortality and morbidity trends and other public health statistic information is conducted and analyzed on a routine basis in order to assess the state of health in Douglas County and identify populations at risk for the provision of intervention services.

The Deputy Medical Examiner, with the Douglas County Sheriff's Office, notifies DCHSS of all child deaths, unusual deaths that may have public health significance, and deaths related to communicable diseases. Child deaths are reviewed by the Douglas County Child Fatality Review Team. Cases of attempted suicide are also reviewed by this team. Currently, Douglas County does not have a Medical Examiner on contract, but has been utilizing the State Medical Examiner.

#### **b. Goals**

- a) One hundred percent (100%) of birth and death certificates that are submitted to the Douglas County Vital Records Office are reviewed by the County Registrar or a Deputy Registrar for accuracy and completeness following established Vital Records Office procedures prior to registration and issuance of certificates
- b) Records are re-verified as complete and accurate at the time the originals are entered into the county computer database
- c) Assure accurate, timely and confidential certification of birth and death events
- d) 100% of birth and death certificates are provided within 24 hours of receipt, unless order received prior to original certificate or some other extenuating circumstance prevents its issuance
- e) Analysis of public health information gathered from birth and death certificate data will contribute to proactive intervention to improve public health

#### **c. Activities**

##### **Target population: Douglas County**

- a) Data collection and analysis of health indicators related to morbidity and mortality
- b) Birth and death reporting, recording, and registration
- c) Analysis of services provided with technical assistance from the Department of Human Services

- d) Requests from walk-in customers are filled while the customer waits, once the customer's identification has been proven, their right to obtain a copy of the record has been established, and payment made. Certified copies of registered birth and death certificates are issued within one (1) working day of request.
- e) Death certificates are usually ordered by the funeral home. One hundred percent (100%) of these orders are filled within 24 hours of receipt of the request, unless extenuating circumstances occur.
- f) Birth and death certificates are ordered by customers. Once the foregoing criteria are established, the certificate is mailed or picked up at the Roseburg Vital Records office.

**b. Evaluation**

- a) One hundred percent (100%) of birth and death certificates provided within 24 hours of receipt, unless extenuating circumstances occur.
- b) Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

### **III.19 Action Plan: Information and Referral**

#### **a. Current Condition**

DCHSS provides accurate and unbiased information and referral about local health and social services to the citizens of Douglas County. Information and referral is provided through response to telephone inquiries, providing information and referral information through news releases, presentations, printed materials, the County's website, and by communicating in-person to DCHSS clients.

DCHSS telephone numbers and facility addresses are listed in phone directories, local newspapers, brochures, local and state websites, and community resource directories. The Roseburg DCHSS reception operates on Monday to Friday 8 am to 5 pm. DCHSS reception for outlying clinics in Canyonville, Drain, and Reedsport operate on the following days only: Canyonville – Tuesday, Wednesday, Thursday 8 am to 5 pm; Drain – Wednesday, Thursday 8 am to 5 pm and Fridays 8 am to 4 pm; Reedsport – Mondays and Tuesdays 9 am to 4 pm. Specific program clinic hours i.e. Immunizations, Family Planning advertised on clinic cards, website and said locations.

DCHSS provides information and referrals that are culturally appropriate. DCHSS utilizes a Portland-based interpreter telephone service and three local contracted translators as necessary for language translation including updating program specific forms.

The Public Health Division serves as a local resource to the community for information and data concerning the specific public health issues confronting the Douglas County community.

#### **b. Goals**

- a) To provide timely and accurate Public Health information on the DCHSS webpage
- b) To integrate functions within DCHSS to streamline services from all divisions, providing better service to customers
- c) To distribute Public Health information via local media releases

#### **c. Activities**

##### **Target population: Douglas County**

- a) Review and revision of phone book listings to ensure accuracy and ease of use
- b) All brochures and other resources are reviewed annually and updated as needed

#### **d. Evaluation**

- a) Public Health customer satisfaction survey

- b) Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

#### **IV. Additional Requirements**

- a. See the DCHSS organizational chart.
- b. The Douglas County Board of County Commissioners is comprised of three elected officials. The Board of Commissioners / Board of Health conducts formal weekly meetings on Wednesdays at 9am. One commissioner is assigned to serve as liaison to DCHSS. The DCHSS Administrator attends weekly Board meetings, and meets with the assigned liaison commissioner every 1-2 weeks to discuss operational issues and to provide programmatic updates.
- c. The Public Health Division has a taskforce that meets 3-4 times per year to receive updates in program issues, review and approve any additional material for the client population. This group is comprised of physicians (OB/GYN), managed care partners, hospital partners, local CCF, school superintendent, DHS Service Area Director, member from FQHC, Department of Justice, and local program staff. During this last year the taskforce has been challenged to identify a solution to the closure of the Douglas County Prenatal Clinic. The result of multiple meetings is a collaborative approach to clinic operations between the hospital, managed care provider, FQHC and Douglas County. This plan will allow women to continue to receive integrated care at a familiar and accessible location. This allow for seamless connection between pregnancy testing services and prenatal care.
- d. Triennial Review: All identified compliance items were resolved in December of 2009.
- e. Senate Bill 555: The Douglas County Commission on Children and Families (CCF) is under the governance of the Douglas County Board of Commissioners. The local Commission director and the DCHSS Public Health Division Director have established a working relationship to provide services and care to children and families of Douglas County. The Public Health Division Director has been involved from the early planning phases of all parts of the Senate 555 Plan. Together, the Public Health Division Director and the local CCF Director have coordinated trainings for the community on child development, brain research, and have worked closely with the community to have a smooth, coordinated home visit program between Babies First/Maternity Case Management and Healthy Start.

#### **V. Unmet Needs**

- a. Adequate Funding for Public Health

Douglas County continues to have many unmet public health needs, the largest of which is lack of public health funding. Continued budget cuts to the Public Health Division in fiscal year 2008-2009 and in the next four years will exacerbate an already diminished capacity to provide basic public health services, much less to respond to threats to public health. Rural timber communities across Oregon and the nation have historically received federal timber funding. There is at this point in time no resolution to the O&C federal dollars for support of local county government.

In anticipation of the loss of funding, the Douglas County Public Health Division was instructed by the Board of Commissioners to reduce the Public Health Division budget for 2011/2012 by \$301,894.

The Board of Commissioners will contribute County General Fund to the Public Health Division budget to shore up Public Health Services during fiscal year 2011-2012, but the long-term sustainability of Public Health and other county services remains uncertain. In an effort to meet program requirements, the Public Health Division will pursue partnerships and funding opportunities, and will continue to educate the public about the importance of public health.

Douglas County's public health infrastructure has declined over the past several years. Inadequate funding to Public Health continues negatively impact on our ability to provide both basic and other public health services. In fiscal year 2004-2005, the Public Health Division had a budget that supported 64.7 FTE. In fiscal year 2011-2012, the Public Health Division will have an expected staffing of 34.9 FTE. With a reduction in staff comes a reduction in services, reduction in revenue, and a reduction in matching funds. A cut of this magnitude has had and will continue to have a far-reaching impact on all Public Health Programs and the health of our community.

As the silent insurance policy for all county citizens, Public Health at the local, regional, state, and national level is failing its citizens and the citizens. The short-term impact of reduced or eliminated public health services will lead to long-term effects on the health of children, families, and communities throughout Douglas County and Oregon. Funding public health is not a short-term fix, but a long-term solution.

b. Public Health Accreditation

The national initiative for public health accreditation demands that Douglas County begin work to complete the accreditation prerequisites, including the development of a comprehensive community health assessment, a community health improvement plan, and a local health department strategic plan. In October 2008, Oregon's Coalition of Local Health Officials (CLHO) released a report on the status of Public Health in Oregon. The CLHO report identified a 48 percent gap between a fully-functional public health system and the system that currently exists in our Southern Oregon region. The current challenges are in staffing to accomplish this work. Douglas County was not successful in

the NW Health Foundation grant process for receiving funding for staff support to further complete the Community Health Needs Assessment. In August 2009 the Douglas County Public Health Division completed a preliminary Standards and Measures self-assessment to identify strengths and gaps in agency performance. A Healthy Communities Capacity Building Assessment was conducted in cooperation with the Cow Creek Band of Umpqua Tribe of Indians. The Public Health Division Director has continued to participate in the Accreditation Workgroup, and attending the Quality Improvement Training in The Dallas in November of 2011. Quality Improvement tools are already being put into action within the Public Health Division.

c. Substance Abuse

A public health priority in Douglas County, and all communities, is substance use and abuse—including tobacco use, alcohol abuse, prescription drug abuse, marijuana use and other illegal drug use. Substance abuse during pregnancy, underage drinking, excessive alcohol use and other drug abuse take a huge toll on entire communities. Continued budget cuts to Douglas County Public Health and to Public Health throughout Oregon have begun to erode upstream efforts to prevent substance abuse and its short and long-term costs and consequences. Funding decisions must be reprioritized and redirected to prevent the conditions that lead to substance abuse and to provide adequate treatment at the local level. The Public Health Division will continue to provide support and expertise to local efforts to address the problem of substance abuse in Douglas County.

d. Inadequate Public Transportation

Douglas County is geographically larger than most Oregon counties. Approximately 70% of the county's population lives outside of the Roseburg area core where most health and social services are located. The county's transportation needs far surpass current capacity provided by special transportation services (e.g., Umpqua Transit and Umpqua Valley disAbilities Network, Dial-a-Ride). Unmet mobility needs are greatest in the smaller cities and unincorporated rural areas of the County where transportation service is limited or nonexistent. Limited public transportation continues to be a primary concern and challenge for county residents.

e. Urgent Care as Primary Care

Non-urgent use of emergency rooms is an indicator of a growing public health concern. When hospital emergency rooms and urgent care clinics are used for primary care, recipients of care do not receive efficient, coordinated and continuous care. Those who rely on emergency rooms for primary care are typically those who are most at risk of poor physical, oral, and mental health—uninsured, underinsured children, pregnant women, adults, and the elderly. Budget cuts to public health services for uninsured and

underinsured residents guarantee an increase in non-urgent emergency room visits and a corresponding increase in costs to taxpayers.

Public Health in Douglas County and in Oregon has been weakened by a long succession of cutbacks and shifting priorities. Public health capacity in Douglas County, in Oregon, and nationally is in need of rebuilding not further shrinkage. State and federal funding decisions must prioritize upstream public health efforts to reduce the escalating costs and consequences of downstream public health problems. Unfortunately, it is the more vulnerable among us—uninsured and underinsured children, pregnant women, and elderly, and others who count on public health—are the ones who are hit harder and faster by a weakened public health infrastructure.

For those who are more fortunate, public health is largely invisible until there is a food borne illness outbreak at a church picnic, their child's daycare is closed due to an outbreak of pertussis, or there is a flu outbreak or threat of new super-bug, or media attention to a nationwide disease outbreak related to a contaminated food product. Only a public health system that has the capacity to meet day-to-day health challenges will have the capacity needed to prevent or respond to public health threats and emergencies.

## **VI. Budget**

The Douglas County Health and Social Services budget planning for Fiscal Year 2012/2013 will not begin until February 2012 and will not be complete until June of 2012. For budget information, please contact:

Douglas County Health and Social Services  
Attention: Jeremiah Elliott, Business Services Manager  
621 West Madrone St.  
Roseburg, OR 97470  
(541) 440-3835

## VII. Minimum Standards

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

### Organization

1. Yes  No  A Local Health Authority exists which has accepted the legal responsibilities for public health as defined by Oregon Law.
2. Yes  No  The Local Health Authority meets at least annually to address public health concerns.
3. Yes  No  A current organizational chart exists that defines the authority, structure and function of the local health department; and is reviewed at least annually.
4. Yes  No  Current local health department policies and procedures exist which are reviewed at least annually.
5. Yes  No  Ongoing community assessment is performed to analyze and evaluate community data.
6. Yes  No  Written plans are developed with problem statements, objectives, activities, projected services, and evaluation criteria.
7. Yes  No  Local health officials develop and manage an annual operating budget.
8. Yes  No  Generally accepted public accounting practices are used for managing funds.
9. Yes  No  All revenues generated from public health services are allocated to public health programs.
10. Yes  No  Written personnel policies and procedures are in compliance with federal and state laws and regulations.
11. Yes  No  Personnel policies and procedures are available for all employees.
12. Yes  No  All positions have written job descriptions, including minimum qualifications.
13. Yes  No  Written performance evaluations are done annually.
14. Yes  No  Evidence of staff development activities exists.

15. Yes  No  Personnel records for all terminated employees are retained consistently with State Archives rules.
16. Yes  No  Records include minimum information required by each program.
17. Yes  No  A records manual of all forms used is reviewed annually.
18. Yes  No  There is a written policy for maintaining confidentiality of all client records which includes guidelines for release of client information.
19. Yes  No  Filing and retrieval of health records follow written procedures.
20. Yes  No  Retention and destruction of records follow written procedures and are consistent with State Archives rules.
21. Yes  No  Local health department telephone numbers and facilities' addresses are publicized.
22. Yes  No  Health information and referral services are available during regular business hours.
23. Yes  No  Written resource information about local health and human services is available, which includes eligibility, enrollment procedures, scope and hours of service. Information is updated as needed.
24. Yes  No  100% of birth and death certificates submitted by local health departments are reviewed by the local Registrar for accuracy and completeness per Vital Records office procedures.
25. Yes  No  To preserve the confidentiality and security of non-public abstracts, all vital records and all accompanying documents are maintained.
26. Yes  No  Certified copies of registered birth and death certificates are issued within one working day of request.
27. Yes  No  Vital statistics data, as reported by the Center for Health Statistics, are reviewed annually by local health departments to review accuracy and support ongoing community assessment activities.
28. Yes  No  A system to obtain reports of deaths of public health significance is in place.

29. Yes  No \_\_\_ Deaths of public health significance are reported to the local health department by the medical examiner and are investigated by the health department.
30. Yes  No \_\_\_ Health department administration and county medical examiner review collaborative efforts at least annually.
31. Yes  No \_\_\_ Staff is knowledgeable of and has participated in the development of the county's emergency plan.
32. Yes  No \_\_\_ Written policies and procedures exist to guide staff in responding to an emergency.
33. Yes  No \_\_\_ Staff participate periodically in emergency preparedness exercises and upgrade response plans accordingly.
34. Yes  No \_\_\_ Written policies and procedures exist to guide staff and volunteers in maintaining appropriate confidentiality standards.
35. Yes  No \_\_\_ Confidentiality training is included in new employee orientation. Staff includes: employees, both permanent and temporary, volunteers, translators, and any other party in contact with clients, services or information. Staff sign confidentiality statements when hired and at least annually thereafter.
36. Yes  No \_\_\_ A Client Grievance Procedure is in place with resultant staff training and input to assure that there is a mechanism to address client and staff concerns.

#### **Control of Communicable Diseases**

37. Yes  No \_\_\_ There is a mechanism for reporting communicable disease cases to the health department.
38. Yes  No \_\_\_ Investigations of reportable conditions and communicable disease cases are conducted, control measures are carried out, investigation report forms are completed and submitted in the manner and time frame specified for the particular disease in the Oregon Communicable Disease Guidelines.
39. Yes  No \_\_\_ Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or communicable disease case received.
40. Yes  No \_\_\_ Access to prevention, diagnosis, and treatment services for reportable communicable diseases is assured when relevant to protecting the health of the public.

41. Yes  No  There is an ongoing/demonstrated effort by the local health department to maintain and/or increase timely reporting of reportable communicable diseases and conditions.
42. Yes  No  There is a mechanism for reporting and following up on zoonotic diseases to the local health department.
43. Yes  No  A system exists for the surveillance and analysis of the incidence and prevalence of communicable diseases.
44. Yes  No  Annual reviews and analysis are conducted of five year averages of incidence rates reported in the Communicable Disease Statistical Summary, and evaluation of data are used for future program planning.
45. Yes  No  Immunizations for human target populations are available within the local health department jurisdiction.
46. Yes  No  Rabies immunizations for animal target populations are available within the local health department jurisdiction.

#### **Environmental Health**

47. Yes  No  Food service facilities are licensed and inspected as required by Chapter 333 Division 12.
48. Yes  No  Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.
49. Yes  No  Training in first aid for choking is available for food service workers. (We provide a handout card describing first-aid for choking. Training is provided in the community.)
50. Yes  No  Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided. (We provide information to food handlers and complainants. We also provide brochures and information via the Health Department website.)
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. (This is accomplished through the Planning Department)
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. (This is provided through County Public Works.)
62. Yes  No  Indoor clean air complaints in licensed facilities are investigated.
63. Yes  No  Environmental contamination potentially impacting public health or the environment is investigated.
64. Yes  No  The health and safety of the public is being protected through hazardous incidence investigation and response.
65. Yes  No  Emergency environmental health and sanitation are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control.
66. Yes  No  All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448.

### Health Education and Health Promotion

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

### Nutrition

73. Yes  No  Local health department reviews population data to promote appropriate nutritional services.
74. The following health department programs include an assessment of nutritional status:
- a. Yes  No  WIC
  - b. Yes  No  Family Planning
  - c. Yes  No  Parent and Child Health
  - d. Yes  No  Older Adult Health
  - e. Yes  No  Corrections Health
75. Yes  No  Clients identified at nutritional risk are provided with or referred for appropriate interventions.
76. Yes  No  Culturally and linguistically appropriate nutritional education and promotion materials and methods are integrated within programs.
77. Yes  No  Local health department supports continuing education and training of staff to provide effective nutritional education.

### Older Adult Health

- 78. Yes  No  Health department provides or refers to services that promote detecting chronic diseases and preventing their complications.
- 79. Yes  No  A mechanism exists for intervening where there is reported elder abuse or neglect.
- 80. Yes  No  Health department maintains a current list of resources and refers for medical care, mental health, transportation, nutritional services, financial services, rehabilitation services, social services, and substance abuse services.
- 81. Yes  No  Prevention-oriented services exist for self health care, stress management, nutrition, exercise, medication use, maintaining activities of daily living, injury prevention and safety education.

### Parent and Child Health

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

91. Yes  No  Use of fluoride is promoted, either through water fluoridation or use of fluoride mouth rinse or tablets.
92. Yes  No  Injury prevention services are provided within the community.

### **Primary Health Care**

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

### **Cultural Competency**

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

## Health Department Personnel Qualifications

### Local health department Health Administrator minimum qualifications:

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

Administrator name: Peggy Kennerly

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     No x

Has the Administrator taken a graduate level course in epidemiology? Yes     No x

Has the Administrator taken a graduate level course in environmental health? Yes     No x

Has the Administrator taken a graduate level course in health services administration? Yes     No x

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

**1. Yes     No x The local health department Health Administrator meets minimum qualifications:**

As Health Department Administrator I am also responsible for Mental Health, Developmental Disabilities Services, Senior Services, Volunteer Services, Veteran Services and Public Transportation. With the increased workload it has not been possible to add online classes to the work day.

Peggy Madison, Douglas County Health & Social Services

2. 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.**

3. 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.**

4. Yes  No  The local health department Health Officer meets minimum qualifications:

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

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

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

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

\_\_\_\_\_  
Local Public Health Authority

Douglas  
County

\_\_\_\_\_  
Date

**BOARD OF COUNTY COMMISSIONERS**  
Joseph Laurance - Chair  
Doug Robertson – Commissioner  
Susan Morgan – Commissioner

Deputy Administrator  
Michael Kurtz  
Performance Standards  
Research and Development  
Compliance

**Douglas County Department of Health & Social Services**  
Peggy Madison, Administrator

Michelle Endicott  
Executive Administrative Assistant

**Administrative and Department Services**  
Jeremiah Elliott  
Business Services Director

Administrative Mgmt.  
Financial Services  
MIS / IT  
Client Services  
Vital Records  
Special Transportation  
Public Transit  
Preparedness

**Mental Health and Developmental Disabilities Services**  
Janet Holland  
Division Director

Mental Health Services:  
Crisis Services  
Adult Clinical Service  
Child Clinical Service  
PSRB  
Mediation  
Outpatient Treatment  
Resource Management  
Medical Services  
Fowler House  
Developmental Disabilities Services:  
Case Management  
Protective Services

**Public Health**  
Dawnelle Marshall  
Division Director

Immunizations  
Women & Adult Health  
Prenatal Clinic  
Family Planning  
WIC  
Communicable Disease Control  
Health Education  
Epidemiology  
Laboratory Testing  
Licenses/Inspections  
Water Program  
Training/Education

**Senior and Veterans Services**  
Michael Kurtz  
Deputy Administrator

Senior Services:  
Information & Referrals  
Senior Meals  
Legal Assistance  
Oregon Project Independence  
Veterans Services:  
Information and Referrals  
Claims Advocate  
Outreach Services

**FAMILY PLANNING PROGRAM ANNUAL PLAN  
FOR FY 2013**

July 1, 2012 to June 30, 2013

As a condition of Title X, funding agencies are required to have a plan for their Family Planning Program, which includes objectives that meet SMART requirements (**S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**ime-Bound). In order to address state goals in the Title X grant application, we are asking each agency to **choose two** of the following four goals and identify how they will be addressed in the coming fiscal year:

- Goal 1:** Move forward with adapting family planning and reproductive health services to the requirements of state and national health care reform, including the use of electronic health records, partnering with Coordinated Care Organizations (CCOs), investigating participation in health insurance exchanges, etc.
- Goal 2:** Assure ongoing access to a broad range of effective family planning methods and related preventive health services, including access to EC for current and future use.
- Goal 3:** Promote awareness and access to long acting reversible contraceptives (LARCs).
- Goal 4:** Address the reproductive health disparities of individuals, families, and communities through outreach to 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) and by partnering with other community-based health and social service providers.

The format to use for submitting the annual plan is provided below. Please include the following four components in addressing these goals:

- 1. Problem Statement** – For each of two chosen goals, briefly describe the current situation in your county to be addressed by that particular goal. The data provided may be helpful with this.
- 2. Objective(s)** – Write one or more objectives for each goal. The objective(s) should be realistic for the resources you have available and measurable in some way. An objective checklist has been provided for your reference.
- 3. Planned Activities** – Briefly describe one or more activities you plan to conduct in order to achieve your objective(s).
- 4. Evaluation** – Briefly describe how you will evaluate the success of your activities and objectives, including data collection and sources.

Specific agency data is also provided to help with local agency planning. If you have any questions, please contact Carol Elliot (971 673-0362) or Connie Clark (541 386-3199 x200).

**FAMILY PLANNING PROGRAM ANNUAL PLAN FOR  
COUNTY PUBLIC HEALTH DEPARTMENT  
FY 2013**

July 1, 2012 to June 30, 2013

Agency: Douglas County

Contact: Dawnelle Marshall

**Goal # 2**

<b>Problem Statement</b>	<b>Objective(s)</b>	<b>Planned Activities</b>	<b>Evaluation</b>
Currently 36.55 of clients are leaving the clinic with EC. Some clients decline need or use.	Maintain current percentage (36.5%) of clients left the clinic with EC as one of the available methods.	1. Education regarding all methods of BC. 2. Continue offering EC for future use.	Annual evaluation of method data Review of rolling PG rate data.

**Goal # 3**

<b>Problem Statement</b>	<b>Objective(s)</b>	<b>Planned Activities</b>	<b>Evaluation</b>
Currently offer Mirena and Paraguard as long action BC. Currently no providers are trained in Implanon.	To expand LARC at clinic locations to include Implanon.	1. To recruit additional provider for clinic. 2. Get NP's trained in insertion and removal.	Completion of recruitment, training and implementation of Implanon.

- Objectives checklist: findings?
- X Does the objective relate to the goal and needs assessment findings?
  - X Is the objective clear in terms of what, how, when and where the situation will be changed?
  - X Are the targets measurable?
  - X Is the objective feasible within the stated time frame and appropriately limited in scope?

**Progress on Goals / Activities for FY 2012**

(Currently in Progress)

The annual plan that was submitted for your agency last year is included in this mailing. Please review it and report on progress meeting your objectives so far this Fiscal Year.

Goal / Objective	Progress on Activities																		
Changes in reimbursement and county general fund have led to challenges in providing services at all locations in Douglas County.	Measure number of clients served at each clinic location/month: In FY 2010/2011 FP served 2605 non duplicated clients <table border="1" data-bbox="592 1003 1437 1234"> <thead> <tr> <th></th> <th>Annual / Initials</th> <th>Office Visits</th> </tr> </thead> <tbody> <tr> <td>Canyonville Office:</td> <td>70</td> <td>318</td> </tr> <tr> <td>Drain</td> <td>52</td> <td>211</td> </tr> <tr> <td>Reedsport</td> <td>26</td> <td>278</td> </tr> <tr> <td>Roseburg</td> <td>1175</td> <td>3123</td> </tr> <tr> <td>Total</td> <td>1323</td> <td>3930</td> </tr> </tbody> </table>		Annual / Initials	Office Visits	Canyonville Office:	70	318	Drain	52	211	Reedsport	26	278	Roseburg	1175	3123	Total	1323	3930
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Canyonville Office:	70	318																	
Drain	52	211																	
Reedsport	26	278																	
Roseburg	1175	3123																	
Total	1323	3930																	
Changes in funding and resources had led to challenges in maintaining a broad range of birth control methods.	Fees have been updated.																		

# Local Public Health Authority Immunization Annual Plan Checklist July 2012-June 2013

## Douglas County Health Department

LHD staff completing this checklist: Karen Vian, RN

### **State-Supplied Vaccine/IG**

- 1. Uses the Oregon Immunization Program (OIP) Vaccine Administration Record (VAR), or a county VAR given prior approval by OIP
- 2. Accurately codes all immunizations according to OIP Vaccine Eligibility Charts
- 3. Pays quarterly Billable Project invoices in timely manner

### **Vaccine Management & Accountability**

- 4. Has an assigned immunization program coordinator
- 5. Uses OIP-approved Standard Operating Procedures for Vaccine Management
- 6. Uses and maintains OIP-acceptable refrigeration equipment
- 7. Uses and maintains OIP-acceptable temperature tracking, calibrated and certified thermometers in every vaccine containing refrigerator & freezer
- 8. Has an OIP-approved vaccine emergency plan
- 9. Complies with OIP vaccine expiration & wastage requirements

### **Delegate Agencies**

- 10. Has one or more delegate agencies: LHD has up-to-date addendum agreements for each site  N/A
- 11. Has one or more delegate agencies: LHD has reviewed each site biennially, following OIP guidelines  N/A

### **Vaccine Administration**

- 12. Has submitted annual Public Provider Agreement & Provider Profile
- 13. Provides all patients, their parents or guardians with documentation of immunizations received
- 14. Complies with state & federal immunization-related document retention schedules
- 15. Does not impose a charge for the cost of state-supplied vaccines or IG, except for Billable Project or Locally Owned doses
- 16. Does not impose a charge of more than \$15.19 per dose for VFC/317 vaccine
- 17. Does not deny vaccine administration to any VFC or 317-eligible patient due to inability to pay the cost of administration fee, and waives this fee if client is unable to pay

### **Immunization Rates & Assessments**

- 18. Participates in the annual AFIX quality improvement immunization assessment and uses rate data to direct immunization activities

### **Perinatal Hepatitis B Prevention & Hepatitis B Screening and Documentation**

- 19. Provides case management services to all confirmed or suspect HBsAg-positive mother-infant pairs
- 20. Has a process for two-way notification between LHD and community hospital infection control or birthing center staff of pending deliveries by identified HBsAg-positive pregnant women
- 21. Enrolls newborns into case management program & refers mother plus susceptible household & sexual contacts for follow-up care
- 22. [Multnomah County only] provides centralized case management work over the tri-county area of Washington, Clackamas & Multnomah  N/A
- 23. Documents & submits to OIP the infant's completion or status of 3-dose Hepatitis B vaccine series by 15 months of age (excluding Washington & Clackamas counties)  N/A
- 24. Works with area hospitals to promote the Hepatitis B birth dose vaccine to all infants and Hepatitis B vaccine and IG to affected infants whose mothers are HBsAg positive or whose status is unknown
- 25. Screens all pregnant women receiving prenatal care from public programs for HBsAg status or refers them to other health care providers for the screening
- 26. Works with area hospitals to strengthen hospital-based screening & documentation of all delivering women's hepatitis B serostatus
- 27. If necessary, has an action plan to work with area hospitals to improve HBsAg screening for pregnant women
- 28. Requires and monitors area laboratories & health care providers to promptly report HBsAg-positive pregnant women

### **Tracking & Recall**

- 29. Forecasts shots due for children eligible for immunization services using ALERT IIS
- 30. Cooperates with OIP to recall any patients who were administered sub-potent (mishandled or misadministered) vaccines

### **WIC/Immunization Integration**

- 31. Assists and supports the Oregon Health Authority (OHA) to provide WIC services in compliance with *USDA policy memorandum 2001-7: Immunization Screening and Referral in WIC*

### **Vaccine Information**

- 32. Provides to patients or patient's parent/legal representative a current VIS for each vaccine offered
- 33. Confirms that patients or patient's parent/legal representatives has read or had the VIS explained to them, and answers questions prior to vaccine administration
- 34. Makes VIS available in other languages

### **Outreach & education**

35. Designs & implements a minimum of two educational or outreach activities in each fiscal year (July 2012 through June 2013). [Can be designed for parents or private providers and intended to reduce barriers to immunization. This can not include special immunization clinics to school children or for flu prevention.] **Report activity details here:**

Reminder/recall letters done monthly for specific cohorts seen in the Douglas County Health Department main site and three satellite clinics. Cohorts include 5 months of age and past due, 13 months of age and due now, and 16 months of age past due.

Reminder/recall letters done monthly for newly reported Hepatitis C confirmed cases recommending the Hepatitis A and Hepatitis B vaccine series and related availability of 317 vaccine eligibility if they qualify.

(Activity 3)

### **Surveillance of Vaccine-Preventable Diseases**

36. Conducts disease surveillance in accordance with *Communicable Disease Administrative Rules*, the *Investigation Guidelines for Modifiable Disease*, the *Public Health Laboratory Users Manual*, and OIP's *Model Standing Orders for Vaccine*

### **Adverse Events Following Immunizations**

37. Completes & returns all reportable LHD patient adverse event VAERS report forms to OIP

38. Completes the 60-day and/or 1-year follow up report on prior reported adverse events if requested by OIP

39. Completes & returns VAERS reports on other adverse events causing death or the need for related medical care, suspected to be directly or indirectly related to vaccine, either from doses administered by the LHD or other providers

### **School/Facility Immunization Law**

40. Complies with Oregon School Immunization Law (ORS 433.235-433-284)

a. Conducts secondary review of school & children's facility immunization records

b. Issues exclusion orders as necessary

c. Makes immunizations available in convenient areas and at convenient times

41. Completes & submits the required annual Immunization Status Report to OHA by the scheduled deadline

42. Covers the cost of mailing/shipping: school exclusion orders to parents, and packets to schools & other facilities

### **American Recovery & Reinvestment Act (ARRA) Stimulus Funds**

43. Completes and meets all ARRA (state and federal) reporting requirements **including the ARRA Final Summary Report by November 30, 2011.**

Report submitted?  Yes  No

### **Performance Measures**

44. Meets the following performance measures: [Refer to your 2011 Performance Measure spreadsheet]
- Yes  No: 4<sup>th</sup> DTaP rate of  $\geq 90\%$ , or improves the prior year's rate by 1% or more
  - Yes  No: Missed Shot rate of  $\leq 10\%$ , or reduces the prior year's rate by 1% or more
  - Yes  No: Correctly codes  $\geq 95\%$  of state-supplied vaccines per guidelines in ALERT IIS
  - Yes  No: Completes the 3-dose hepatitis B series to  $\geq 80\%$  of HBsAg-exposed infants by 15 months of age
  - Yes  No: Enters  $\geq 80\%$  of vaccine administration data into ALERT IIS within 14 days of administration

### **Terms & Conditions Particular to LPHA Performance of Immunization Services**

- 45. Reimburses OHA for the cost of wasted state-supplied vaccines/IG when required
- 46. Returns at LHD's expense all styrofoam containers shipped from Oregon Immunization Program (and not by McKesson)
- 47. Participates in state-sponsored annual immunization conferences, and uses dedicated OIP-provided funds for at least one person to attend

### **Reporting Obligations & Periodic Reporting**

- 48. Submits, in timely fashion, the following reports (along with others required & noted elsewhere in this survey):
  - Monthly Vaccine Reports (with every vaccine order)
  - Vaccine Orders (according to Enhanced Ordering Cycle [EOC] assignment)
  - Vaccine inventory via ALERT IIS
  - Immunization Status Report
  - Annual Progress Report
  - Corrective Action Plans for any unsatisfactory responses during triennial review site visits  N/A

# Non-Compliance Explanation Detail Sheet

Use these table rows to document any checklist statements you were unable to check off or answer with a “Yes”. Be sure to insert the corresponding statement number for each response.

<p>Q. 44 Douglas County can not check 'yes' as the 4<sup>th</sup> DTaP rate as figured in the 2011 Performance Measures is not over 90% or did not raise by 1% in the last year. The performance measure regarding 3 dose Hepatitis B series is NOT APPLICABLE - I was unable to answer the question with a yes or no answer. To bring our program into compliance, we will continue to forecast the 4<sup>th</sup> DTaP at the earliest age possible and we implemented letters to three cohorts under the age of 24 months in June 2011 in order to remind and recall for the 4<sup>th</sup> DTaP and other antigens. The 2010 Douglas County Population Based Rates (unpublished) measure the 4<sup>th</sup> DTaP rate at 83.9% which is an increase of 6.3% since 2009 for Douglas County. Douglas County's PBR 4<sup>th</sup> DTaP rate is 2.7% above the statewide average. Douglas County also runs monthly benchmark reports out of ALERT IIS to monitor 4<sup>th</sup> DTaP rates. Douglas County requests that the Oregon Immunization Program import and export statewide a client's ALERT IIS status from 'active' to 'moved out of the area' based on monthly data available from WIC about who is on the Oregon WIC Program and who has moved out of state; this could provide for a more accurate cohort of who to calculate the 4<sup>th</sup> DTaP rate on.</p>
<p>Q. 48 It is Douglas County's understanding that the Vaccine Inventory is not an area of the new ALERT IIS that we should be using at this time (November 2011) as we submit our data electronically. Please advise Douglas County when you want us to start using the Vaccine Inventory piece of ALERT IIS.</p>
<p>Q. 8 We have an approved plan in place, but Douglas County's Vaccine Emergency Plan is dated 2006. Douglas County will update it before June 2012 or earlier.</p>
<p>Q.</p>

**To Submit:**

1. Save and print this document for your records
2. Include a copy with Agency Annual Plan
3. Submit as an attachment via e-mail to: [OregonVFC@state.or.us](mailto:OregonVFC@state.or.us)

