

LANE COUNTY PUBLIC HEALTH AUTHORITY
COMPREHENSIVE PLAN SUBMITTED DECEMBER 2011
FOR FISCAL YEAR 2012/13

I. Executive Summary

The Annual Plan submitted for FY 2012-2013 for Lane County includes the following narrative sections: an assessment which provides demographic and public health indicators for Lane County; a description of the delivery of local public health services; an action plan for the delivery of core public health services; a description of unmet needs; and a checklist of compliance with the minimum standards. The local public health authority must assure activities necessary for the preservation of health or prevention of disease. Through the Intergovernmental Agreement with Oregon Health Authority, Lane County accepts the role of the local public health authority within the Board of County Commissioners. The Board delegates the responsibility for adhering to the requirements in the program elements of the agreement and assuring activities are accomplished to the Department of Health and Human Services, of which Lane County Public Health is a division.

The mission of Lane County Public Health is to preserve, protect and promote the health of all people in Lane County. We have continued to refer to the five year strategic plan developed in 2009. The process staff participated in allowed us to think through what public health is, what we value in looking at the health of our communities, and what strategies we can put into place for the present and long term health effects. A tracking grid was also developed in 2009 and 2010 as a companion document to the plan in order for us to determine what we are accomplishing in relation to our objectives. Our Public Health Advisory Committee was involved in this process which enriched the product and understanding of what public health's role is in a community. Overarching goals in the plan are: 1. Service Integration (The community experiences accessible, aligned and adaptable public health services); 2. Communication (Public Health is valued and supported by the community); 3. Leadership (Public Health provides leadership in creating a Healthy Community); 4. Workforce Excellence (Maintain a competent public health workforce); 5. Quality Assurance and Improvement (Public Health continuously improves processes, programs and practices); and 6. Revenue Stability and Enhancement (Public Health has resources to achieve identified goals). Each of these goals are linked to the ten essential public health services that guide and inform the strategic directions of Lane County Public Health.

In July 2010, Lane County Public Health moved into the remodeled Charnelton Building. During our first year in the new facility, staff have initiated strategies to increase access to services and referrals to other department programs in the building, including coordination with the Community Health Center for clinical support.

II. Assessment

Public Health Issues and Needs

Lane County spans an area of 4,620 square miles making it the fifth largest county in Oregon by area. It stretches from the Pacific Ocean, over the coastal mountain range, across the southern Willamette Valley, to the crest of the Cascade Mountains. Although 90 percent of Lane County is forestland, Eugene and Springfield comprise the second largest urban area in Oregon. In addition, the county encompasses many smaller cities and rural communities.

The 2011 estimated population prepared by the Population Research Center of Portland State University for Lane County was 352,010 continuing it as the fourth largest Oregon County by population. The county has seen a steady growth over many years (2010: 351,715; 2009: 347,690; 2008:345,880, 2007: 343,591). US Census Bureau data and Portland State University, Population Research Center data provide a profile of Lane County's 2010 demographics:

- Percentage of persons 0-17 years old was 20.9% (state was 23.01%).
- Percentage of the population living in poverty that are children younger than 18 was 24 %.
- Percentage of persons 18-64 years was 64.5% (state was 63.5%).
- Percentage of the population living in poverty between the ages of 18-64 year old was 69.5%.
- Percentage of persons 65 years old and over was 14.7% (state was 13.5%)
- Percentage of the population living in poverty 65 years and older was 6.5%.
- Lane County population reported in 2010 was 92.3% White with 3.5% Asian, 1.8% American Indian/Alaska Native, and 1.8% Black; .5% Native Hawaiian Islander and Other Pacific; additionally, 7.4% of the population identified as Hispanic or Latino origin.
- The level of educational achievement included 90.2% of the adult population as high school graduates and 27.9% of the population having a bachelor's degree or higher.
- The U.S. Census Bureau for 2010 notes the median household income as \$40,276 compared with \$46,560 in Oregon. The same report notes 19.3% people live below the poverty level.
- The unemployment rate Lane County in September 2011 was 9.6% compared to the state 9.6%. The rate in February 2011 was 10.7% compared to the state 10.9%.

Additional indicators of health and wellbeing (data from Oregon Health Services as well as Lane County Public Health):

- In 2010, 70% of Lane County's 24-35 month-olds received the full recommended series of immunizations (4:3:1:3:3:1 series), compared to 73% at the state level. Lane County Public Health serves 1% of this age population while the private medical community provides the rest of the immunizations.

- Lane County's Religious Exemption rate for immunizations required for kindergarten was 8.4% in 2010-2011. Exemptions are not spread evenly across the county but are disproportionately higher in certain geographic areas. Populations with lower herd immunity are at significantly increased risk for outbreaks of vaccine preventable diseases including measles and pertussis.
- Preliminary and incomplete data for 2011 shows 1,079 reported cases of chlamydia through October 31, putting the number on track to equal the number of cases in 2010
 - 1,281 reported cases in 2010, with an incident rate of 367.52/100,000
 - 1,268 reported cases in 2009, with an incident rate of 365.9/100,000 population
 - 1,052 reported cases in 2008, with an incident rate of 340/100,000 population
- Preliminary and incomplete data for 2011 points to an increase in gonorrhea cases with 73 reported through October 31, 2011.
 - ✓ 43 reported cases in 2010, with an incident rate of 12.33/100,000;
 - ✓ 139 reported cases in 2009, with an incident rate of 39.5/100,000 population,
 - ✓ 101 reported cases in 2008, with an incident rate of 27.8/100,000 population
- Total number of cases of syphilis in 2011 remain small, however the 8 cases reported thus far this year are more than we have seen for over a decade.
- Teen pregnancy rate for 10-17 year olds for 2010 was 5.7 compared to state at 7.1 per 1,000 teens 10-17.
- Teen pregnancy rate for 15-17 year olds for 2010 was 13.0 compared to state at 18.0 per 1,000 teens 15-17.
- 26% of Lane County adults are obese and another 35% are overweight.
- BRFSS 2006-2009 age-adjusted data shows 6.3% of Lane County adults have diabetes (6.8% statewide), 27.3% have high blood pressure (25.8% statewide), 33.6% have high blood cholesterol (33.0% statewide), 10.6% have asthma (9.7% statewide).
- 8% of 8th graders report smoking cigarettes compared to 9% in Oregon.
- 15% of 11th graders report smoking cigarettes compared to 16% in Oregon.
- 4% of 8th graders (males) report using smokeless tobacco compared to 5% in Oregon.
- 14% of 11th graders (males) report using smokeless tobacco compared to 14% in Oregon.
- 18% of adults report smoking cigarettes compared to 17% statewide.
- 24% of all deaths in one year in Lane County are due to tobacco use.
- 15% pregnant women report smoking cigarettes while pregnant, compared to 12% statewide.
- Fetal Infant Mortality rate 2001-2005 for Lane County was 8.25, down from 9.5 in 2000-2004. Oregon's overall rate was 8.0. Lane County's "Reference

Group” rate decreased to 6.9. The most recent U.S. “Reference Group” rate is 5.8.

- In 2010, 49% of pregnant women in Lane County were served by WIC. Statewide it was 46.2%.
- In 2010, 13,548 women, infants and children were served in Lane County through the WIC program. Of those, 9,521 were infants and children under age 5 and 4,027 were pregnant, breastfeeding and postpartum women.
- In 2010, 5,439 families were served in WIC. Of those, 60.3% are working families. In 2009, 68% were working families. (A working family is defined as a household with at least one wage-earning family member.)
- In 2010, 93.8% WIC moms start out breastfeeding.

In 2010, there were 3,493 births to Lane County residents, down from 3,550 in 2009. Over the past ten years, the number of births has remained in the 3,500 to 3,700 per year range.

Births to teen moms as a percentage of total births generally declined over the past ten years. In 2000, the percentage of births to teen moms was 11.9%, and in 2010 the percentage was 7.4%.

In 2010, 63.3% of our Oregon Mothers Care (OMC) clients accessed prenatal care in their first trimester. This downward trend began in 2008 with the implementation of the requirement for a certified birth certificate for application for Oregon Health Plan (OHP) coverage. Prior to the birth certificate requirement, more women were able to access timely prenatal care. For example, 77.1% of OMC clients were able to access first trimester care in 2007.

Overall in Lane County, the percentage of infants born to mothers who had first trimester prenatal care has trended downward from a high of 80.2% in 2001 to 76.8% in 2010. The downturn in the economy and the increase in poverty and homelessness may contribute to decreased early access to care.

In 2010, percentage of births with low birth weight in Lane County was 6.4%. Over the past ten years the percent of low birth weight has gradually trended upward, with 5.7% of births with low birth weight in 2001. Low birth weight and preterm birth and the precursors of these outcomes are serious concerns for our community, particularly in light of Lane County’s unacceptably high rate of fetal-infant mortality.

PRAMS (Pregnancy Risk Assessment Monitoring System) data for Lane County identifies several areas of concern with risk behaviors. Of the respondents, 24.9% admitted to binge drinking (5 or more drinks at one setting) in the three months before pregnancy. 26.1% admitted smoking in the three months before pregnancy. Alcohol and tobacco use are markers for illicit drug use. Alcohol, tobacco, and other drugs have a significant negative impact on birth outcomes,

including birth weight and preterm birth. (Note: this data is based on the state's analysis of combined 2000-2004 PRAMS data. We do not have updated data at this time.)

Fetal-Infant Deaths

The incidence of fetal-infant mortality in a community is measured by the number of fetal and infant deaths per 1,000 live births and fetal deaths. The rate of fetal-infant mortality serves as a measure of a community's social and economic well-being as well as its health. Lane County's overall fetal-infant mortality rate has shown a decrease to 8.25 in the most recent data for Perinatal Periods of Risk 2001-2005. Community efforts to maintain and enhance this downward trend continue.

Lane County Public Health used the Perinatal Periods of Risk (PPOR) approach to investigate local fetal-infant mortality. PPOR is an evidence-based, internationally respected approach that looks at fetal and infant deaths in relation to weight at birth and age at death. The PPOR analysis revealed an unacceptably high rate of fetal-infant mortality in Lane County. Additionally, the PPOR results indicated that the problem was wide-spread and significant in all population groups regardless of economic, educational, geographic, age, and cultural status. Finally, the PPOR analysis revealed that the most excess deaths occurred in the post-neonatal period from one month to one year of age. The results of the PPOR analysis were shared with the broader community: and, from the resulting community concern, the Healthy Babies, Healthy Communities (HBHC) initiative was born.

Next steps in investigating Lane County's high rate of fetal-infant mortality was to initiate a prospective, individual case-finding approach that would help clarify causes of death, identify missed opportunities for effective interventions, and address policy challenges. Members of the HBHC initiative identified Fetal Infant Mortality Review (FIMR) as the strategy to use in case-finding reviews. FIMR was developed by the Maternal Child Health Bureau and the American College of Obstetricians and Gynecologists, and is a well-established and evidence-based approach. During the FIMR data gathering phase, information on the fetal or infant death is collected from medical records and a maternal home interview. This information is compiled and de-identified. It is then reviewed to identify critical community strengths and weaknesses, as well as unique health and social issues associated with poor outcomes. Recommendations for new policies, practices, and/or programs are developed and shared with the broader community. Identified issues are prioritized, and appropriate interventions are implemented.

After three years of the FIMR analysis, a number of common issues have been identified: a lack of pre-pregnancy health, health care, and reproductive planning; significant alcohol, tobacco, and other drug use immediately before and during pregnancy; a lack of understanding regarding the negative impact that the use of

alcohol, tobacco, and other drugs has on fetal health and development; a lack of consistent and comprehensive prenatal risk screening and follow-up for psychosocial issues, alcohol, tobacco, and other drug use, domestic violence, and mental health issues; and significant unsafe infant sleep practices and confusion around co-sleeping.

Adequacy of Local Public Health Services

The budget approved for FY 11/12 maintained the local public health authority, a value deeply held by the Board of County Commissioners. LCPH will begin the budget process for FY 11/13 in December 2011. We are involved in discussions with the Community Health Centers (CHC) of Lane County, a division of the H&HS Department, to strategize how to maximize billing options under the CHC, especially for our MCH and CD programs. One example that we have begun for FY 11/12, was a different billing strategy was developed, thus reducing the need for MCH general funding by \$175,000 while projecting that amount of funding via the billing process with the CHCLC. The Budget Committee has not yet begun its deliberations on the budget so we wait for further direction at both the state and federal levels for budget information. The consideration of reductions in our immunization and state support funding through the Oregon Health Authority brings great concern for our ability to continue meeting all the requirements of the program elements for such funding. Reduction of funding in the special projects immunization will hamper our ability to provide the level of oversight and work our staff has done in the immunization program. There is also the looming concern that Lane County will not be receiving any timber funds in one year, which will greatly impact LCPH since we do receive funds to support our Communicable Disease, Maternal Child Health and WIC programs.

LCPH has a Public Health Supervisor on-call at all times (24/7/52). The on-call supervisor is reached through an answering service. This supervisor is able to call on other management and nursing staff resources as needed to manage the public health need. Presently, due to the support of the county general fund, the communicable disease team is able to meet current expectations unless we have a large event or outbreak which would quickly overwhelm the local resources at public health. Through our effort with the H1N1, we have been able to seek volunteer nurses as well as extra help nurses to provide vaccinations, but to also have a cadre of nurses available should we need to call for additional assistance for any future outbreaks.

The Maternal Child Health Program receives many hundreds of referrals for Maternity Case Management for pregnant women and teens at risk of poor pregnancy and birth outcomes, Babies First! Targeted Case Management for infants at risk for developmental delays, and CaCoon Targeted Case Management for medically-fragile infants and their families. Only a fraction of those receive nurse home visiting services due to staffing limitations. Beginning in August 2011, the MCM home visiting billing process came under the

Community Health Centers of Lane County. This has provided revenue to make up for some of the loss of county general funds. The MCH team is working on new strategies to increase the number of home visits nurses can provide.

The Maternal Child Health Nurse Supervisor brought together an internal departmental team and community partners to discuss the county's high fetal infant mortality rate. As part of the identification of best practices to reduce fetal-infant mortality, the community coalition has determined that Public Health has inadequate capacity to provide long term, comprehensive nurse home visiting for families at risk of poor pregnancy and infancy outcomes. Research indicates that nurse home visiting needs to begin early in pregnancy and continue to age two. The high number of excess deaths between age 29 days and one year in Lane County indicate a great need for nurse home visiting (particularly for families with high psycho-social risks) to teach injury and SIDS prevention and child health and development needs. Because local hospitals and medical providers know that we are limited to six field nurses, they only refer infants with high medical/developmental risks. And, although we serve pregnant women with social risk factors through maternity case management, we have been unable to continue serving their infants through Babies First unless there is a medical condition. The limited number of staff dictates that we offer services to families with the highest risks. This limitation means we are limiting access to other families with unmet needs.

Lane County was awarded a grant to begin a Nurse Family Partnership (NFP) program in 2012. NFP is an evidence-based, community health program that helps transform the lives of vulnerable mothers pregnant with their first child. The goals of the NFP program are to improve pregnancy outcomes by helping women engage in good preventive care; improve child health and development by helping parents provide responsible and competent care; and to improve the economic self-sufficiency of the family by helping parents develop a vision for their future, plan pregnancies, continue their education, and find work. Because of the grant, we will be able to hire two additional nurses and will be able to serve more pregnant women. We are eager to begin the development of this outstanding nurse home visiting program.

Our WIC staff provides an exemplary level of service to the families they serve. The team has been able to incorporate creative strategies to keep the caseload numbers up including development of streamlined schedules and processes in order to provide the nutrition education, assessment and voucher distribution needed. The myriad of required complexities within the WIC program continues to challenge us in serving the number of clients who qualify for the program. At this time, it is apparent that the need for WIC services has increased along with other service needs accompanying the economic downturn. The program is currently maintaining approximately 101% of assigned caseload.

The Environmental Health program includes a staff of 11.6. Staff is presently able to tend to all the required inspections of the licensed facilities in the county. In addition, work continues on maintaining an electronic food handler testing program as well as walk in services for reading and testing for food handler cards. The Environmental Health Specialist staff has successfully built positive working relationships with the food industry as well as tourist and travel industry. The EH staff includes a Community Health Analyst 2 who works on preparedness and CD case investigations, especially those related to noro-virus, including outbreaks in nursing homes and large gatherings. The Environmental Health program leads the state in the number of food manager training courses (ServeSafe) provided in Lane County and will be hosting classes in both English and Spanish in February 2012. The Environmental Health program continues an effective State Drinking Water Program.

Provision of Five Basic Services (ORS 431.416)

Communicable Disease

Epidemiology

Public Health communicable disease surveillance and reporting activities vary with the year.

The annual flu season for the fall and winter of 2010 and 2011 was more normal than the previous year of the H1N1 pandemic. Scaled back surveillance from the fall of 2010 through the current flu season (fall and winter of 2011 and 2012) indicates that the circulating influenza viruses are, largely, well matched to the current trivalent vaccine which includes H1N1 as a component of the seasonal vaccine. The ongoing challenge is to assure an appropriate level of understanding and respect for influenza, leading to appropriate prevention activities even during low incidence years.

In 2010, Lane County Public Health (LCPH) recorded 930 reportable communicable diseases, not including sexually transmitted diseases (STDs) or HIV. In the first 10 months of 2011, there have been 827 such reports. Of these total numbers, 612 in 2010, were newly reported cases of chronic hepatitis C. In addition there were 5 cases of newly acquired acute hepatitis C. The numbers of newly reported cases of hepatitis C thus far in 2011 continue a pace with 466 chronic cases and 4 acute cases. This blood borne disease, which unlike hepatitis A & B, is not vaccine preventable, is taking on increased public health significance as people, infected years or even decades ago, age and their long undiagnosed infection progresses to serious liver disease. Also of concern is the new transmission of hepatitis C to individuals. With the one year funding support from the state extended through December and potentially longer, LCPH has

been participating in an enhanced surveillance project for those individuals between ages 15 and 30 with newly reported hepatitis C. This subset of individuals can be presumed to have acquired the infection relatively recently and to be at increased risk of transmitting it to others. Enhanced surveillance is supported by the Centers for Disease Control and Oregon Public Health and is aimed at detecting transmission patterns among these individuals and providing education and prevention counseling.

Another communicable disease of note is the continued presence of cases of pertussis, or Whooping Cough, in our community as well as in outbreaks in other parts of the country. LCPH received 52 reports of pertussis in 2010 and 42 cases in the first 10 months of 2011. This undoubtedly under represents the burden of disease in Lane County. It is significant that pertussis is a vaccine preventable disease that carries significant risk to young children and individuals with certain chronic illnesses and immune disorders. Some of these individuals cannot be immunized, or do not mount an effective immune response when vaccinated. It is important the community around them maintain a high level of vaccination to reduce the chance that the most vulnerable individuals are protected.

Among the sporadically reported diseases were dengue or “Bone break fever” - a mosquito borne tropical illness seen in an international aid worker, 2 cases of tularemia, which can be a bio-terrorism pathogen but – as in these cases – can also be transmitted by rabbits and other wild or domestic farm animals through tick, mosquito and fly vectors, and 2 cases of listeriosis. The majority of our work was related to the more common diseases including pertussis, salmonellosis, hepatitis C, Giardiasis, and campylobacteriosis. With increasingly sophisticated laboratory testing and reporting capabilities, local health departments are often able to determine if cases or outbreaks are related to cases in other jurisdictions or part of a wider outbreak requiring a coordinated public health response. Example: both listeriosis and E.coli have made national and international news in the last 6 months with hundreds of cases and significant numbers of deaths. With newer, specific pulse-field gel electrophoresis (PFGE) testing, which looks at the genetics of the organism involved, it was possible to assure ourselves that the Lane County cases of these diseases were unrelated to the deadly E.coli illnesses in Europe or the listeriosis cases to Colorado grown cantaloupe. In contrast, such testing has also identified that several *Cryptococcus gattii* cases found this summer in Lane County are related to cases stemming from areas of British Columbia. Such information is important to provide the media and the community with risk reduction messages, reassurance regarding the safety of the food chain, and maintenance of public health control efforts.

In June 2011, LCPH responded to an outbreak of a severe initially unidentified respiratory illness in a Lane County care facility. Three programs within LCPH - the Communicable Disease, Environmental Health, and Preparedness Programs - worked quickly and effectively with the facility and its contracted infection

control provider to identify the organism and limit the outbreak. Consultation and joint meetings were held with the state epidemiologists, the local PeaceHealth Lab, hospital infectious disease specialists and doctors to expedite the proper diagnosis, treatment, and control of the outbreak. The final case count was 23, including 7 hospitalizations and 3 deaths. The organism was identified as human metapneumovirus. The effective public health outbreak effort required a rapid and sustained response for 2 weeks. Communicable disease nurses, Preparedness coordinators, supervisors and support staff were fully occupied with this effort during that time.

Outbreaks can happen at any time and the necessary work can last from a mere few days to a year (as in the cases of H1N1). The capacity to rapidly respond and sustain an effective response is crucial to controlling the spread of disease and preventing or reducing the serious consequences including deaths.

In order to remain current and prepared to respond safely and effectively to public health events and to provide clinical services including immunizations, STD exams and treatment, tuberculosis case management, and laboratory services, the LCPH Communicable Disease Team must participate in regular trainings covering multiple disciplines.

Here is a listing of many of the mandatory or essential trainings that designated members of the LCPH Communicable Disease team participated in between October 2010 and October 2011. Hundreds of hours of training are directed to the Communicable Disease Team.

- Respiratory Protection Plan & Fit testing
- LCPH Emergency Response Plans
- Blood Borne Pathogen
- Health Alert Network
- Communicable Disease (epidemiology) 101
- Communicable Disease (Outbreak Investigation) 303
- Forensic Epidemiology
- Isolation & Quarantine
- Outbreak exercises
- Laboratory packaging
- Hazardous Materials training
- Media and risk communication trainings
- Immunization Data Registry trainings
- Vaccine Eligibility coding
- Immunization Delegate Site Review
- STD Clinical Update
- Disease specific trainings such as tuberculosis and *Cryptococcus gattii*
- Position specific preparedness trainings including
 - FEMA Communication & Information Management
 - FEMA - Resource Management

- FEMA – Multiagency Coordination
- Introduction to Incident Command

LCPH completed the transition to the state ORPHEUS database for communicable disease reporting. With strict confidentiality protections in place, the database has improved the cooperative reporting between the county and the state as well as with surrounding counties in select situations.

Tuberculosis

Lane County continues to be a low incidence area for active tuberculosis. Tuberculosis cases in 2010 and 2011 were both foreign born and home grown, with 2 related cases stemming from the long ago illness of a deceased relative in another state. All of the individuals with tuberculosis who were in the working age group were employed. None of the cases in 2010 were homeless. The travel and immigration patterns of Lane County residents in recent years make the constant surveillance and effective response to even one case of tuberculosis in our community essential.

The purposes and responsibilities of the LCPH Communicable Disease Program, Tuberculosis section are:

- To prevent the spread of active tuberculosis disease to people in Lane County
- To prevent outbreaks of tuberculosis in specific groups and populations. Recent examples of Lane County specific outbreaks include residential facilities, private workplaces, and schools.
- To reduce the development of active tuberculosis disease in the pool of tuberculosis infected individuals

These responsibilities are carried out by LCPH using the evidence based standards of tuberculosis control in conjunction with the Oregon Health Authority HIV-STD-Tuberculosis Program.

- To identify and report every case of active tuberculosis disease in the county
- To assure initiation and completion of treatment of every case of active tuberculosis disease in the county, called “Tuberculosis Case Management” – a six month to one year process for each case.
- To complete an extensive case investigation for each case of active tuberculosis disease in order to identify exposed contacts to the case, those infected, and assure completion of preventative medication treatment.

Effective and sufficient response requires a knowledgeable and resource adequate response at a local and state public health level in conjunction with local health care providers in the private sector. Delay in identifying or adequately meeting these responsibilities in even one case of active, infectious, tuberculosis disease can result in spread to the immediate population contacts of the case, and from there into the wider community, exponentially increasing both the burden of disease and the medical and economic costs to the individuals and wider community.

TB Case Management is a service that only local public health provides. It is the cornerstone of effective evidence based control of tuberculosis and consists of the following work:

- Identification of the disease by sophisticated, multifaceted process including, local and state laboratory identification at specific intervals from suspicion of disease, through confirmation 4-6 weeks later. During this interval, the case is managed and treated by LCPH as if the disease is present.
- Assuring the client has a private health care provider (pulmonologist, infectious disease doctor, internist, family practice doctor, nurse-practitioner, or physicians assistant) – whether or not the client is able to pay for the service. This can be a complex and ongoing process throughout the course of treatment.
- The LCPH Nurse TB Case Manager acts in collaboration with the private physician, providing education and for those who may have limited or no experience in treating a client with tuberculosis, and assuring adequacy and completion of treatment.
- Consultation and collaboration with LCPH Health Officer and state tuberculosis program including participation in TB cohort review process.
- Nurse TB Case Manager home/hospital visits with the client and family to provide initial education and expectations for the period of treatment. These initial visits are challenging since the individual is learning that their activities (work, church, social, and family) will be restricted until it is demonstrated that they are no longer contagious. The individual also learns that LCPH will be providing daily, observed, 4 drug therapy through this period followed by twice weekly therapy until the documented cure and end of treatment many months later.
- DOT – Directly Observed Therapy is the evidence based international standard for treatment of active tuberculosis disease. Examples of the places that LCPH has provided DOT include: homeless shelters and river camps, private homes from Florence to rural East Lane County, and worksites throughout the County.
- Ongoing LCPH nurse evaluations to assure that the client is not experiencing serious side effects (including vision and liver) from the treatment and to assure that the client is keeping appointments with the private provider and required X-rays and laboratory testing.

- Contact Investigation involves identifying the contacts of all active cases and screening them all for TB infection, both immediately upon identification and two months later. Frequently it is necessary to provide TB education to those involved to try to minimize misunderstanding and anxiety. In one case in 2009, an exchange student at a rural school, over 100 contacts were identified and tested at one and 3 months to prevent further spread. Infection was identified in 3 contacts and 9 months of LCPH treatment for these 3 were provided.
- Case management services often need to be provided in a culturally sensitive manner and in languages other than English. Examples from recent cases include Spanish and indigenous languages from Mexico and Central America, Chinese, Vietnamese, and Central African languages.

Private medical providers do not perform these functions. Tuberculosis as a disease and as a public health issue can not be managed alone by private providers. This is the evidence based assessment both internationally and nationally.

One new, or suspected, case of active tuberculosis takes the full time work of a LCPH TB Nurse Case Manager for at least 2 weeks followed by months of ongoing daily then weekly work with the support of the Health Officer, Community Service Worker, and Office Assistants. An outbreak requires these resources plus much of the time of the other nurses and nursing supervisor and support from the state tuberculosis program

LCPH currently has two individuals being provided TB Nurse Case Management. There were 6 individuals who completed treatment for active tuberculosis between October 2010 and now. One other individual was also treated for active tuberculosis and moved during the course of his treatment. LCPH works with the receiving public health jurisdiction – be it another county or another country - to assure completion of treatment. LCPH also has between 10 and 25 individuals with latent TB infection medications that require at least monthly assessment and management.

In addition LCPH provides education and assessment services to community members and organizations to aid the identification and prevent the spread of tuberculosis. At a minimum we provide billable tuberculosis testing for 5 employers and treatment centers. We also provide twice yearly LCPH TB nurse inspections of the ultraviolet light system at the Eugene Mission which were installed during the most recent homeless shelter outbreak in Lane County. We provide consultation to other organizations which are developing their own tuberculosis prevention programs. We have developed and maintain a comprehensive internal Respiratory Exposure Prevention Protocol including initial tuberculosis testing of all public health employees and annual fit testing of respiratory protection equipment for employees whose work may put them at risk

of exposure. Finally, we continue to provide ongoing B2 Waiver tuberculosis evaluation and follow-up for those referred from immigration services.

Sexually Transmitted Disease Control Measures

The majority of reported cases of STDs come from private providers and not from public health clinics. Lane County Public Health, unlike private providers, is the entity responsible for assuring treatment of contacts of reportable STDs and, therefore, reducing the spread of these diseases throughout the population.

Chlamydia remains the disease with the highest case counts of any reportable communicable disease in Lane County. In 2010, LCPH received 1,281 reports of chlamydia with an incidence of 367 reported cases per 100,000 population. In the first 10 months of 2011, LCPH has received 1,079 reports of chlamydia. In addition, with most cases of chlamydia being asymptomatic, it is estimated that the true case count is three to four times greater.

There were 43 reports of gonorrhea with an incidence of 12/100,000 in 2010. Thus far in 2011, LCPH has received 73 reports of gonorrhea and 6 cases of syphilis.

Surveillance reports show that the greatest burden of disease is in those people less than 25 years of age. These numbers do not reflect the increased morbidity, including hospitalizations or fertility impacts such as increased ectopic pregnancies, in those who sustain complications from chlamydia or gonorrhea infection.

LCPH has initiated a monthly "Get Yourself Tested" campaign and drop-in STD clinic focused on those under 30 years old. As our promotional campaign continues, we anticipate that the clinic will continue to grow.

In response to the move to our new facility in the Charnelton Building and to address points in the 2010 Triennial Review, LCPH has written a new lab manual. The manual is focused on specific policies and procedures for nurses providing the STD examination and treatment client services, as well as attending to lab sample collection and packaging in accordance with state and OSHA requirements.

LCPH has transitioned to the statewide ORPHEUS database for STD reporting. This is facilitating confidential communication and morbidity reporting with the state as well as with other counties. In addition, database security and access has improved communication between the LCPH staff and the off site state Disease Information Specialist who investigates high risk STD cases such as gonorrhea, chlamydia in pregnant women, and syphilis.

Immunizations

The purpose of the LCPH Communicable Disease Immunization Program is to reduce the incidence of vaccine preventable diseases in the community. LCPH work includes a comprehensive program of community vaccination assessment, delegate immunization partner education and management, health care provider education and training, community education, provision of direct immunization services, and vaccine management. The LCPH Immunization Program operates in partnership with the Oregon Public Health Division Immunization Program, health care providers in the county, and with schools.

LCPH provides immunization support to nine delegate clinics. At present these include five school based health centers, three Community Health Centers of Lane County, and Health Associates in Florence. The services that LCPH provides to these delegate sites include:

- Training for providers, nurses, and administrative support staff to provide sustainable safe, effective, and accurate immunization services
- Initial, annual, and as needed training on vaccine eligibility, coding, and charging
- Training and ongoing support for vaccine storage and management
- Access and follow-up support and training for the ALERT IIS Immunization data Registry – an evidenced based best practice for assuring and improving childhood immunization rates
- Training and support for vaccine reporting to assure compliance with requirements for use of state and federal vaccine
- Access to federal and state programs providing state of the art vaccine refrigerators and monitoring equipment and assistance in setting up and using this equipment.

LCPH, with the support of the Oregon Public Health Division Immunization Program, is the only entity that provides these services in our county. In the 2010 state Immunization Program Triennial Review of our program, the reviewer noted the enormous positive impact to the community that results from our coordination and management of our delegate immunization clinics. Immunization delegate management is a large component of the work of the LCPH Immunization Coordinator and Senior Stores Clerk as well as other members of the Communicable Disease Team.

In calendar year 2010, LCPH directly provided 3,443 non-flu immunizations. In the first three quarters of 2011, we gave 2,264 non-flu immunizations. Our delegate clinics provided 7,790 non-flu immunizations in 2010, and 6,818 in the first three quarters of 2011.

In 2010, LCPH prepared and trained to transition to the new state IIS Alert Immunization registry. As the data registry enrolls new providers, opportunities to assure that children's immunization records are accurate and up-to-date continue even as families move from one location and provider to another.

A total of 53,054 school immunization records were reviewed for the 2010/2011 school year for all children in public and private schools and in preschools and certified day care facilities. We worked with 158 school and 152 children's facilities to address omissions in immunization records. On February 2, 2011, school exclusion letters were issued for 2,766 students. Of these, 328 students were excluded from school until immunization records were documented as being in compliance with state requirements. LCPH, therefore, achieved over 99% of our 100% target for completed school immunization exclusion day on February 17.

Since that report, the LCPH Communicable Disease team including the Immunization Program Coordinator, School Immunization Review Coordinator, Public Health Officer, and Nursing Supervisor are continuing to analyze the Religious Exemption and Up-to-Date figures to assess and address the increased local risk for outbreaks of vaccine preventable diseases including measles, mumps, pertussis, and varicella. The Religious Exemption (RE) from required school immunizations increased across Lane County to 5.7% in 2010 from 5.43% in 2009. The RE rate for public school kindergarten children is 8.4%. This year, for the first time, the report breaks down the exemption by vaccine antigen as well as by individual school.

Our School Immunization Coordinator works with each school's representative to update them on immunization and reporting requirements, educate them on the vaccines and their importance, and provide them with tools and evidence-based resources to help counsel families who are weighing the decision to vaccinate or claim religious exemption. She has had some measurable successes with several schools whose improved rates of up to date records are reflected in the report.

On October 10, Dr. Patrick Luedtke, Lane County Public Health Officer, made a presentation at the Peace Health Pediatric Grand Rounds on the "Rising Number of Religious Exemptions in Lane County".

LCPH remains a good steward of our expensive and fragile vaccine resources. Our immunization program continues to exceed the performance measure target of 95% in vaccine accountability.

The LCPH Communicable Disease Program is also collaborating with the Community Health Centers of Lane County to identify opportunities to work together to coordinate and improve immunization services for Community health Center clients and to support the broader LCPH Immunization program.

HIV

The LCPH HIV Program continues to focus program resources and efforts on testing and prevention services to populations at greatest risk for disease. This emphasis is reflected in both our in-house and outreach efforts at LCPH and in our support and collaboration with our subcontracted agency, HIV Alliance. As funding at both the state and local level continue to decrease, we continue to strive to increase accessibility to members of these populations.

HIV Counseling Testing and Referral Services (CTRS) are provided by appointment and, when possible, for clients who drop-in. In 2010 and 2011, LCPH provided these services in-house and also at Willamette Family Treatment Service sites. Outreach and testing was also provided at Buckley Detox & Sobering Station. Wednesday afternoons remain a reserved and promoted time for testing men who have sex with men (MSM) at LCPH. In addition, the LCPH HIV counseling and testing staff member collaborate with HIV Alliance to provide HIV testing at special events such as Project Homeless Connect, the University of Oregon during times dedicated to awareness and services to African American/Black and Latino communities, and to Latino clients at Centro Latino Americano.

LCPH has a Performance Measure to focus at least 65% of our HIV testing to populations at increased risk of HIV including MSM, injection drug users (IDU), and sex partners of people in these populations. In 2010 and thus far in 2011, LCPH and its subcontracted partner together have exceeded this goal every month. In 2010 total of 1,032 HIV tests were provided. LCPH itself provided 410 of these HIV tests, exceeding our goal of 400.

LCPH continues to actively support and participate in the Lane County Harm Reduction Coalition (LCHRC) which consists of private and public partners with the purpose of reducing the impact of injection drug use and other substance abuse on public safety, community health, and individual health.

Funding for HIV Prevention from the Centers for Disease Control and Prevention is being restructured to align with national priorities to increase resources to areas where there is an increased prevalence of HIV. Oregon is a low incidence state and will receive reduced funding. Within Oregon, Lane County is one of seven counties with highest incidence and prevalence of HIV. It is anticipated that Lane County will continue to receive some HIV Prevention Funding, although in decreasing amounts over the next 4 years. Prevention activities that are to be undertaken with these funds include: HIV testing; comprehensive prevention with positives; condom distribution; and policy and structural initiatives. When the funding figures are known, LCPH will need to determine where the required

core components can best be met. Careful evaluation of both the LCPH HIV Program and the subcontracted services at HIV Alliance is being undertaken.

Both HIV Alliance and LCPH have seen a recent increase in numbers of clients testing positive for HIV. Preliminary data through September 2011 shows that LCPH has tested 288 individuals and 6 have tested positive since the start of the calendar year. HIV Alliance has tested 480 individuals and 13 have tested positive.

LCPH Communicable Disease Program Summary

In summary, the work of the LCPH Communicable Disease Program consists of population focused services and programs in the following areas:

- Communicable Disease – prevention, surveillance, reporting, treatment
- Outbreak management
- Tuberculosis
- Sexually Transmitted Diseases
- Immunizations
- HIV prevention, surveillance, and testing

The same 3 to 4 Community Health Nurses and 2 Community Services Workers, supported by a Health Officer, Nursing Supervisor, Senior Stores Clerk, and 2.5 Office Assistants, provide all the client services, community and provider education, planning, enacting, and reporting for all of these programs. To address specific community health issues, they serve on multiple state and local committees including: CLHO/Epi, CLHO/HIV, Lane Harm Reduction Coalition as well as on program, division, and Lane County H&HS department committees to address the priorities of our organization.

Parent and Child Health Services

The Oregon Mothers' Care (OMC) program helps low-income pregnant women establish health insurance coverage with Oregon Health Plan (OHP) and helps ensure the initiation of prenatal care with local medical care providers. Prenatal access works in collaboration with hospitals and private providers to increase access to early prenatal care; and works in collaboration with Maternal Child Health nurses and WIC staff to provide a system of services for vulnerable families. Approximately 392 low income pregnant women were served in 2010. Additionally, the percentage of women who were able to access first trimester prenatal care was lower as a result of the requirement for a certified birth certificate prior to establishing OHP eligibility and early prenatal care.

The Maternal Child Health (MCH) program provides nurse home visiting, education, support, and referral to appropriate medical and developmental services for families at risk of poor pregnancy, birth, or childhood outcomes.

MCH services are provided countywide by a limited number of public health nurses (5.9 FTE). Pregnant women, infants, and young children at highest risk and greatest need are given priority when decisions about which families to serve have to be made. In 2010 MCH nurses provided home visiting for 748 unduplicated clients. Of these, 370 received maternity case management, 321 received Babies First and 57 received CaCoon services. The Maternity Case Management program provides nurse home visiting services for high-risk pregnant women; and, helps assure access to and effective utilization of appropriate health, social, nutritional, and other services during the perinatal period. The Babies First program provides assessment and early identification of infants and young children at risk of developmental delays or other health related conditions. The CaCoon program provides services for infants and children, who are medically fragile or who have special health or developmental needs, by helping their families become as independent as possible in caring for the child and by helping families access appropriate resources and services. Of particular concern for the MCH program is that although we receive 100-200 high risk referrals per month, we are able to serve only those at highest risk.

As of July 1, 2006, the Family Planning (FP) program was moved from the Public Health Division of the Lane County Department of Health and Human Services to the Human Services Commission, also within the Lane County Department of Health and Human Services. The FP clinic is now within the federally qualified health center, also known as Community Health Centers of Lane County. Goals for the FY 11/12 year for the Family Planning Program which fit within the Title X requirements are: 1. To promote awareness and access to emergency contraception among Oregonians at risk for unintended pregnancy. 2) To direct services to address disparities among Oregon's high priority and underserved populations.

Collection and Reporting of Health Statistics

Lane County Public Health provides statistical information to Oregon Health Authority/Public Health Services on a regular basis – including CD reporting on each case investigation; blood work sent to the state lab; inspections conducted by the environmental health staff; HIV program reporting requirements; IRIS, the WIC data system; the immunization data system ALERT; and ORCHIDS MDE for women and children's data.

Health Information and Referral Services

Lane County Department of Health and Human Services and Lane County Public Health (LCPH) publicize location, phone numbers and listing of services. We have developed a web site for the department that has specific information regarding each program within the department. We also have a strong working relationship with the county Public Information Officer (PIO) who assists in disseminating up-to-date information regarding any public health issue in which the community may be interested. The PIO has a section on the general county website for public health issues, such as smallpox, H1N1 and West Nile Virus,

providing easy access for citizens. LCPH has available brochures, the mission statement, and a handout with clinic services, times and locations.

Environmental Health Services

The Environmental Health (EH) program includes the inspections of licensed facilities, primarily food service facilities. The following are the types and numbers of facilities licensed and inspected by the EH staff in 2011: full service and limited service food facility (983), bed and breakfast (15), mobile units (191), commissaries and warehouses (44), temporary restaurants (1083), pools/spas (287), traveler's accommodations (105), RV parks (75), and organizational camps (12), for a total of 2,795. The total in 2011 was 2,681. In addition to license facility inspections, EH staff completed 198 daycare inspections and 171 school/summer food program and miscellaneous kitchen inspections for jails, fraternities, group homes, etc. The EH and CD teams work closely together as needed to ensure safe food and tourist accommodations. In 2011, the following are some of the violations found upon general inspections: improper holding temperatures (423), contaminated equipment (419), and poor personal hygiene (65). Food borne illness continues to be a concern when food is not prepared, served or stored in a safe and sanitary manner. Ongoing monitoring of facilities and training of food service personnel can prevent food borne illness. The EH food handler testing program issued 67,527 food handler cards in Lane County and counties across the state through agreements. Of that total, 1,542 were issued in-house. In addition to the above services, EH also provides Drinking Water Program surveillance to 311 public water systems in Lane County. Approximately 52-55 water system surveys are conducted yearly throughout Lane County.

Adequacy of Other Services

Chronic Disease Prevention

Tobacco use continues to be the leading cause of preventable death in the U.S., Oregon and Lane County. Twenty-two percent of annual deaths in Lane County are attributed to tobacco use. Through minimal state funding, the Lane County Tobacco Prevention and Education Program (TPEP) continues to reduce tobacco-related illness and death by countering pro-tobacco influences, promoting tobacco cessation resources, and eliminating and reducing people's exposure to secondhand smoke through the creation and enforcement of smoke-free environments. (See Tobacco Prevention Program objectives under Action Plan section.)

Lack of physical activity and poor nutrition are the second leading cause of death in Lane County. Twenty-six percent of Lane County adults are obese (70,663) and another 35% (95,122) are overweight. Health consequences of obesity include coronary heart disease, type 2 diabetes, cancers (endometrial, breast, and colon), hypertension, Dyslipidemia (for example, high total cholesterol or high levels of triglycerides), stroke, liver and gallbladder disease, sleep apnea

and respiratory problems, osteoarthritis (a degeneration of cartilage and its underlying bone within a joint) and gynecological problems (abnormal menses, infertility). Obesity is also financially costly for Oregon. A study commissioned by the Northwest Health Foundation found that 34 percent of the increase in Oregon's health expenditures between 1998 and 2005 could be attributed to the rising obesity prevalence. (See Healthy Communities Program objectives under Action Plan section.)

Primary Health Care

In regards to primary health care a division within the Lane County Department of Health and Human Services was established – Community Health Centers (CHC) of Lane County. The central office is called Riverstone, located in Springfield. A second location for the clinic has just been established in the “Charnelton” Building, the building that all public health services are now located (as of July 2010). Having a primary care clinic in the same building as a public health service has been helpful to the people we serve and provides for continued coordination of services between the two divisions. The CHC provides family planning, pediatrics, internal medicine, family practice and now prenatal care.

Medical Examiner

The Deputy Medical Examiner program was moved out of the Lane County Department of Health & Human Services in 2002 to the District Attorney's Office. This seemed to be a more prudent link for the work that is done with the enforcement activities. The Deputy Medical Examiner continues to work with LCPH and the Department in regards to SIDS and those deaths of significant public health concern (e.g. heroin overdoses, adolescent suicides, injuries).

Emergency Preparedness

Preparedness for disasters, both natural and man-made, is a public health priority. The Public Health Emergency Preparedness (PHEP Program) develops and maintains the capacity of the department to rapidly mount an effective response to an emergency and to prevent, investigate, report and respond to outbreaks or the spread of communicable diseases. The PHEP program addresses public health mitigation, preparedness, and response and recovery phases of emergency response through plan development, training and exercise, and plan revision. The program also galvanizes the community to tackle local preparedness needs, and specifically focuses planning for the needs of the community's most vulnerable populations. The program is actively monitored to assure the attainment of professional standards and state/federal guidelines and to evaluate the program's success.

For FY 2011-12, the following objectives have been identified for the PHEP Program:

1. Maintain and update the Lane County Emergency Operations Plan describing the functions, capabilities and procedures necessary to mitigate, respond and recover from a local emergency.
2. Update and implement the Lane County Public Health exercise and training program, including providing regular training opportunities and at least two exercises that increase in complexity and adhere to Homeland Security Exercise and Evaluation Program (HSEEP) guidelines.
3. Provide technical support to the Lane County Vulnerable Populations Emergency Preparedness Coalition and assist with actions identified within the coalition's work plan.
4. Share program accomplishments and lessons learned by presenting at professional conferences.

III. Action Plan

Communicable Disease Program

- **Current condition or problem:**

1. TB case management and DOT for all active TB cases as defined in Program Element 03 of IGA with DHS/Oregon Health Authority.
2. Continued elevated rates of chlamydia.
3. Countywide immune rates for 24-35 month olds (4-3-1; 3-3-1) was just 60.2% in 2009 – the last year that information is available. State wide the percentage is 65.5%.
4. LCPH clinic up-to-date immunization rate for the same antigens in this population is 70%
5. Maintain currency of required staff preparedness trainings.
6. Continued immunization delegate support for 9 clinics.
7. High religious exemption rates for immunizations in certain populations. (See Immunization Action Report)

- **TB Control Measures:**

Goals:

1. Prevention of TB outbreaks at homeless shelter.
2. Provide culturally competent TB case management for all clients.
3. Meet state performance measures in Program Element 03.
4. At least 90% of individuals within LPHA's jurisdiction with newly diagnosed TB, who are identified by or reported to LPHA and for whom therapy for one year or less is indicated, complete therapy within 12 months of the identification or report.
5. Contacts are identified for at least 90% of newly reported or identified sputum AFB-smear positive TB cases within LPHA's jurisdiction.
6. At least 95% of Contacts to reported or identified sputum AFB-smear positive TB cases within LPHA's jurisdiction are evaluated for infection and disease.
7. At least 85% of infected Contacts to reported or identified sputum AFB-smear positive TB cases within LPHA's jurisdiction who are started on treatment for latent TB infection will complete therapy.
8. Assure TB case management staff remain current with standards of care.
9. Assure health and safety of staff when providing TB case management care.

Activities:

1. Twice yearly inspection of the ultra-violet light system (system was installed Fall of 2003.)
2. Assure availability of professional staff with appropriate language skills. Staff will meet required diversity trainings. Individualized

- assessment of client needs include cultural appropriateness of services.
3. Maintain up to date reporting to state to show required performance measures for Program Element 03 are being met.
 4. CD nursing staff and Public Health Officer participate in regular state and in-house TB case management reviews.
 5. Participate in state webinars as offered.
 6. Annual review of the LCPH Respiratory Protection Plan and fit testing of designated staff.

Evaluation:

1. Biannual evaluation of UV lights and monthly logs will show homeless shelter staff following procedures for light maintenance.
2. Continue surveillance and monitoring of TB cases as noted in Program Element 03 of IGA with DHS/Oregon Health Authority.
3. Triennial program review with state and local staff completed September 2010.

• **STD Control Measures:**

Goals:

1. Prevent and control spread of STD's in Lane County.
2. Meet program requirements in Program Element 10.
3. Increase direct STD services to clients.
4. Address STD investigations locally.
5. Clarify nursing standards for scope of practice in STD clinic.

Activities:

1. Annual review of STD protocols to ensure the protocols are in line with CDC and state guidelines.
2. Ongoing CD team review of LCPH STD clinic process.
3. Increase LCPH capacity to provide STD case management.
4. Maintain STD surveillance and reporting process using established community links, local trained staff, and the ORPHEUS data system.
5. Target outreach and clinic availability, in conjunction with state program, to clients at high risk for STD's , including promotion of a monthly drop-in STD clinic for individuals under the age of 30
6. Work with state to optimize community resources in provision of services.
7. Participate in the joint county & state DIS workgroup process.

Evaluation:

1. Staff will enter and monitor program output and outcomes data as part of the countywide performance measure tracking. STD performance measures provide data on reportable STD incidence rates.
2. Any new STD nurse will achieve initial proficiency in STD exams and treatment and case management within 6 months of hire.
3. LCPH STD reporting process will meet state standard for timeliness and completion.
4. LCPH will continue collaboration with state STD program, the Community Health Centers of Lane County, and Planned Parenthood to assure access to STD services during both normal public health activity levels and during times of surge efforts on other communicable disease work.

• **Continued integration and training of applicable preparedness activities and staff with Communicable Disease (CD) program.**

Goals:

1. CD team members will understand and maintain currency of preparedness training.
2. Develop and maintain surge capacity nurse training for CD and preparedness.
 - a. Expand, organize and document CD team preparedness trainings.
 - b. CD team will participate in drafting, reviewing and exercising preparedness plans.
 - c. CD team members will meet trainings required as outlined in preparedness program elements of IGA with DHS/Oregon Health Authority.

Activities:

1. CD nurses will participate in quarterly preparedness staff meetings.
2. Preparedness staff will provide updates during bimonthly communicable disease staff meetings.
3. CD staff will complete required trainings according to the Public Health Training Plan for staff positions.
4. Continue to involve CD staff in appropriate preparedness planning.
5. Participate in preparedness exercises and drills.

Evaluation:

1. Preparedness staff will enter and monitor program output and outcome data as part of the countywide performance measure tracking.
2. At least annually, training records will be examined for progress and achievement of standards.

3. Evaluation of exercises, events will be done in a “Hot Wash” and After Action Reports with the CD team.
 4. Assure CD staff training records are complete.
- Continue to focus on increasing overall immunization rates of 24-35 months olds (served by LCPH).

Goals:

1. Maintain performance measures we have met, including those we continue to work on.
2. Continue to assure current and accurate data on ALERT IIS.
3. Provider information/resources that addresses provider concerns and parent hesitancies regarding vaccines.
4. LPHA shall improve the 4:3:1:3:3:1 immunization series coverage rate by one (1) percentage point each year and/or maintain a rate of > 90% (4 DTaP, 3 IPV, 1 MMR, 3 Hep B, 3 Hib, 1 Varicella). (PE 43 of IGA)
5. LPHA shall reduce their Missed Shot rate by one (1) percentage point each year and/or maintain the rate of < 10%. (PE 43 of IGA). While this remains a state and county goal, LCPH’s unique immunization clinic population includes many parents with vaccine hesitancy. Staff continues to work to provide information and education to these families about each recommended and school required immunization. None-the-less, we do provide all the recommended immunizations that the parent will accept, even if this means that we have missed shots recorded.
6. 95% of all state-supplied vaccines shall be coded correctly per age-eligibility guidelines (PE 43 of IGA).
7. 80% of infants in LPHA’s Service Area exposed to perinatal hepatitis B shall be immunized with the 3-dose hepatitis B series by 15 months of age. (PE 43 of IGA).
8. 80% of all vaccine administration data shall be data entered within 14 days of administration. (PE 43 of IGA)

Activities:

1. Use reports from AFIX to clarify areas of need.
2. Evaluate specific areas, i.e. missed dose rate in AFIX report and obtain name list from state immunization staff to facilitate record evaluation.
3. Review AFIX report with staff and determine if there are areas where staff training/update would be beneficial.
4. Monthly evaluation of code report for accuracy.
5. Systematic monitoring and follow-up for perinatal hepatitis B.
6. Data entry of all immunizations given within 14 days of administration.
7. LCPH partner with state in discussions to provide information/resources to providers regarding vaccine hesitancies.

Evaluation:

1. Complete review of AFIX report annually for missed doses and up to date information compared to goal.
2. Discussion of AFIX findings at Communicable Disease Team meeting annually.
3. Review state evaluation of perinatal hepatitis B and address discrepancies.
4. Compare monthly report of vaccine coding and compare to goal in contract performance measures.
5. Provider assessment regarding concerns regarding children's vaccinations.

HIV Program

Current condition or problem:

1. The population in Lane County includes residents at high-risk of acquiring and spreading HIV infection.
2. Lane County Public Health (LCPH) has a well-established HIV counseling and testing program which includes outreach and education to members of groups at increased risk for HIV.
3. LCPH maintains a contractual relationship with a community-based organization (HIV Alliance) for further provision of services to clients with HIV and those at risk.
4. LCPH is an active participant in Lane County Harm Reduction Coalition.

Goals:

1. Prevent spread of HIV Disease.
2. Provide HIV Core Component HIV Prevention services in alignment with CDC priorities.
3. Increase rates of testing in populations high-risk for HIV infection.
3. Link individuals at risk with other LCPH prevention services.
4. Provide counseling, testing information and referral services to individuals within targeted high-risk groups.

Activities:

1. Provide confidential and anonymous HIV counseling and testing per DHS/Oregon Health Authority contract per minimum service requirements.
2. Review current program plans with the state HIV program and adjust based on new CDC guidance of priorities and Core Components as well as spending reductions.

3. Provide community outreach to MSM and injecting drug populations to encourage HIV counseling and testing, and education as to how to prevent the transmission of the HIV virus.
4. Through participation on the Harm Reduction Coalition, LCPH will continue to provide leadership and partnership with other organizations to support programs and events that help prevent the spread of HIV infection.
5. Continue to support subcontracted agency on their best practice programs, including counseling and testing and needle exchange activities.
6. Direct provision of LCPH services such as STD exams and treatment and/or referrals such as HIV case management per IGA with DHS/Oregon Health Authority.

Evaluation:

1. HIV program staff will maintain data as required by DHS/Oregon Health Authority and CDC, per the intergovernmental agreement (IGA).
2. Staff will enter and monitor program output and outcome data as part of countywide performance measure tracking.
3. Ongoing coordination and contract monitoring regarding HIV prevention services with subcontracted agency.
4. We will meet our performance measure goal of 65% or greater testing for high-risk populations.
5. Upon review of the Program Plan with the state, we will see that we are meeting our stated targets.

Collection and Reporting of Health Statistics

Current condition or problem:

As of April 1, 2007 the registrar for birth and death records/certificates and the Vital Records staff moved to the Public Health Division. It was previously housed in the Department of Health and Human Services Administrative Office. Public Health programs do data entry for individual programs – WIC, Maternal Child Health, Family Planning, Immunizations. Having the Vital Records program housed with public health has proven valuable especially as we have established the Fetal Infant Mortality Review team and have had statistics available for the team.

Goal:

Maintain current data entry in order that all statistics are up to date and provided to the state in timely manner.

Activities:

1. 100% of death certificates submitted by Lane County Dept. H&HS are first reviewed by the local registrar for accuracy and completeness per Vital Records office procedures. (Per change in policy directive from state, birth certificates are no longer reviewed.)
2. All vital records and all accompanying documents are maintained in a confidential and secure manner.
3. Certified copies of registered birth and death certificates are issued immediately upon request at the walk-in counter or optimally within two business days of receipt by mail when all required documentation is available from the state. Staff are available from 8:00 am to 11:30 am and 1:00 to 4:30 pm five days per week.
4. Vital Records staff provide fetal death reports to nurse supervisor for ongoing FIMR work to reduce fetal/infant mortality.
5. Staff continue to answer many inquiries regarding obtaining birth certificates six months of age and older from the state vital records office.

Evaluation:

1. Public Health staff will continue to verify the accuracy and completeness of death certificates.
2. Public Health staff will continue to monitor that mailed requests for certificates are issued within two working days of request when required documentation is available from the state.
3. Public Health staff will monitor data entry and ensure that entries are done in a timely manner and that revenue is received on a monthly basis due to the data entry.

Environmental Health Program

Current condition or problem:

1. There are more than 2,500 facilities in Lane County providing eating, living and recreational accommodations for public use.
2. The EH and CD teams of LCPH collaborate regarding food borne investigations, animal bites and more currently with increased incidence of noro-virus in nursing care facilities.
3. The EH team is actively involved in preparedness training and interagency exercises. One Environmental Health Specialist (EHS) is trained as an emergency preparedness Public Information Officer.
4. One new EHS personnel attended the latest state orientation meeting for new EHS personnel.
5. One EHS personnel will attain national training in Pool Operator Certification.
6. The EH program now includes inspections of State Drinking Water systems. Lane County has 311 public water systems that require

routine sanitary surveys. One EHS leads the Drinking Water Program with three EHS trained as back-up.

7. The Preparedness and Environmental Health teams are developing an Environmental Health Surety Plan.

Goals:

1. Ensure licensed facilities in Lane County are free from communicable diseases and health hazards.
2. Continue to focus attention on Food Service Management and Supervisory personnel training.
3. Continue to work on FDA Program Standards.
4. Update electronic inspection program to a web-based platform in cooperation with the State Environmental Health Program.
5. Ensure all state drinking water systems in Lane County are free from communicable diseases and health hazards as noted in the State Drinking Water (SDW) IGA.
6. Conduct inspections of licensed facilities in a timely manner as required in the State Food Program (SFP) IGA.
7. Coordinate food-borne investigations with CD team.
8. Continue follow-up on citizen complaints in a timely manner as noted in the SFP IGA.
9. Provide food handler and food facility management education, testing and licensing as required in the SFD IGA.
10. Continue to provide nursing home training regarding prevention of noro-virus.
11. Conduct inspections of state drinking water systems in a timely manner as required by the SDW IGA.
12. Follow-up on drinking water alerts and non-compliance issues as required by the SDW IGA.
13. Complete the Environmental Health Surety Plan.
14. Work towards combined epi work (CD, EH, Prep.) in responding to public health events.

Activities:

1. Conduct health inspections of all licensed facilities as required by the State Food Program (SFP) IGA.
2. Conduct inspections of unlicensed facilities as requested by those facilities (certified day cares, group homes, jails, sororities, fraternities).
3. Maintain on-line and walk-in testing and licensing for food handlers and managers in Lane County as required by SFP IGA.
4. Perform investigations for citizen complaints on potential health hazards in licensed facilities as required by SFP IGA.
5. Perform epidemiological investigations related to public facilities as requested.
6. Provide environmental health education to the public as requested.

7. Document, follow-up and communicate with local animal control services and Oregon Health Authority on animal bites as required by DHS. Coordinate with local jurisdictions regarding animal bites.
8. The EH supervisor will continue work with interns on FDA Standards.
9. The EH supervisor will continue work with the Information Services Department, Conference of Local Environmental Health Supervisors (CLEHS) and Oregon Health Services Environmental Health program regarding option of electronic inspection program.
10. The EH Supervisor will work with CD Nurse Supervisor to develop noro-virus prevention training for nursing homes.
11. The EH Supervisor will ensure that staff is properly trained and oriented to the responsibilities of the recently added State Drinking Water Program.
12. The EH Supervisor will work with the State Drinking Water Program staff to ensure that all elements of the program are met.
13. Staff are assigned and exercise plans in completing the Environmental Health Surety Plan (according to the Preparedness Training/Exercise Plan).
14. Joint case investigation with CD and EH staff and after action review as indicated/appropriate.

Evaluation:

1. There will be a record and numerical score for each food service inspection. The record will be maintained in the EH database. In addition, a file will be maintained for each facility as required by the SFP IGA.
2. A triennial review of the Drinking Water Program and the Food and Lodging Program will be conducted by a state audit team.
3. Performance measures will be recorded against set targets in the Lane County ScoreCard system.

Family Planning
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).

Health Information and Referral Services

Current condition or problem:

Lane County Public Health provides health information and referral services five days a week in all Eugene program offices

Goal:

To continue providing up-to-date health information and referral services to citizens who call or come into the public health offices.

Activities:

1. Maintain bilingual (English/Spanish) support staff to answer telephone calls and greet people in the office and to provide current health information and referral services as requested.
2. Coordinate information between particular teams within public health and the support staff in order that information is current.
3. Maintain current information regarding clinic hours and services provided through written and oral format as well as website.
4. Maintain current information regarding eligibility and access to services provided by public health.
5. Continue communication with community agencies and medical providers in rural areas of the county for information and referral services in those areas.
6. Maintain current website information.

Evaluation:

1. Structure of support staff schedule will be reviewed to ensure availability of staff to provide health information and referral services.
2. Minutes of public health program team meetings will be kept and shared with support staff to keep up to date information regarding services.
3. Clinic schedules will be reviewed periodically for accuracy – schedules will be provided in English and Spanish.
4. Staff will be encouraged to check the Lane County Public Health website often to make sure the information is accurate. One person maintains website changes and suggestions in order to keep fidelity in the website information.

Healthy Communities Program Objectives

Best Practice Objective #1: Infrastructure for Self-Management Programs, Early Detection and Tobacco Cessation Resources.

SMART Objectives:

1. By June 2012, support Loving Living Well/Tomando Coordinator's (Bev Cridland housed at Peace Health's Gerontology Institute) efforts to maintain our local Living Well/Tomando program delivery

infrastructure and associated referral system by fostering Lane County's Federally Qualified Health Center's interest in participating in the Oregon Primary Care Association's Patient Self-management Collaborative (abbreviated as OPCA PSMC below).

2. By June 2012, all Lane County WIC service delivery staff will continue to implement an evidence-based 3As tobacco cessation intervention with clients who use tobacco, offer tobacco-using clients information on the Quitline, and refer interested and appropriate clients (those interested in quitting in the next 30 days) to the Quitline via the fax referral form [Tobacco Cessation Resources].
3. By June 2012, Lane County will develop and implement an organizational policy to regularly promote the evidence-based Chronic Disease Self-Management Programs (Living Well, tomando and others identified) available in the community to county employees, dependents and retirees living with chronic conditions. [Referral to Self-Management Programs]
4. By June 2012, Lane County will develop and implement an organizational policy to regularly encourage employees, beneficiaries, and retirees to obtain recommended screenings for colorectal, breast and cervical cancer. [Early Detection]
5. By June 2012, Lane County will develop and implement an organizational policy to encourage covered employees, beneficiaries and covered retirees to get recommended blood pressure and cholesterol screenings and follow up with recommended treatment to keep high blood pressure and cholesterol under control. [Early Detection]
6. By June 2012, Lane County will develop and implement an organizational policy to regularly promote the tobacco cessation benefits included in the county's health insurance plan to covered employees, beneficiaries and covered retirees. The Oregon Tobacco Quitline will be simultaneously promoted to county employees and family members ineligible for county health insurance. [Tobacco Cessation Resources]
7. By June 2012, EC Coordinator will continue to participate in quarterly Well Group (local worksite wellness coalition) meetings to encourage other large local employers to consider implementing SMART Objectives 2-6 and other evidence-based worksite wellness policies and interventions at their own organizations.

Best Practice Objective #2: Healthy Worksites

SMART Objectives:

1. By June 2012, goal is that remaining H&HS properties will transition to tobacco-free status and a formal H&HS tobacco-free campus policy will be adopted, incorporated into the Departmental policy manual, and distributed by e-mail to all H&HS staff.

2. By June 2012, establish and implement a regular schedule to conduct tobacco-use environmental assessments at all H&HS properties to ensure compliance with new policy and address problem areas and build champions to continue policy assessment and communication efforts into perpetuity.
3. By June 2012, Lane County Department Directors, Central Administration Office, Human Resources, and Board of County Commissioners/Board of Health will have participated in educational sessions to increase understanding of the importance of adopting a county-wide tobacco-free properties policy.
4. By June 2012, the Lane County Public Health Division (~50 FTE) will adopt and implement a combined healthy food and physical activity at meetings policy for all public health-sponsored meetings and events.
5. By June 2012, conduct Department-wide educational efforts to increase H&HS employees' support for healthier worksite food and physical activity environments.

Best Practice Objective #3: Healthy Retail Environments

SMART Objective

1. By June 2012, workgroup including Lane Coalition for Healthy Active Youth (LCHAY), Public Health, Oregon Research Institute, the Willamette Food and Farm Coalition, Shelter Care, the Housing and Community Services Agency of Lane County, and Dari Mart will develop a policy proposal to increase availability of healthy, affordable food at convenience stores.

ACHIEVE Grant: Lane County Public Health received a three-year CDC-funded technical assistance grant from the National Association of Chronic Disease Directors in February 2011. This three-year initiative, known as ACHIEVE (Action Communities for Health, Innovation, and Environmental Change), includes the creation of a Community Health Action and Response Team (CHART) comprised of community leaders from a variety of sectors. Under this initiative public health will lead collaborative assessments of local worksites, schools, community organizations, health care settings, and the community at large with CHART members. Once the assessment is complete, CHART members will work together to draft and implement a multi-year Community Action Plan focused on chronic disease prevention.

Parent and Child Health

• **Prenatal Access, Oregon Mothers Care:**

Current condition or problem:

1. The percentage of Lane County pregnant women receiving first trimester care in 2010 was 76.8%, a slight improvement. The Oregon percentage in 2010 was 73.4%. The Oregon Benchmark goal is 95%.

2. Lane County's prenatal access program, Oregon MothersCare (OMC) assists pregnant teen and adult women access Oregon Health Plan (OHP) coverage and early prenatal care by helping remove barriers, per program element in the Intergovernmental Agreement with DHS.
3. The local OMC provides education regarding importance of dental care during pregnancy and encourages pregnant women to access dental care.

Goals:

1. Increase the number of pregnant women who access prenatal care during the first trimester as noted in the program element for OMC. (Noted in Program Element 42 in Oregon Health Authority IGA.)
2. Increase the number of OHP eligible pregnant and postpartum women who access dental care services.

Activities:

1. Provide pregnancy testing and counseling, assist in gaining OHP coverage and prenatal care, and referral to MCH and WIC (Special Supplemental Nutrition Program for Women, Infants, and Children).
2. Provide community outreach regarding the need for early prenatal care and the local OMC program as noted in the OMC Program Element.
3. Continue collecting and submitting client data quarterly to state as noted in OMC Program Elements in the IGA with DHS.
4. At each appointment with pregnant woman, staff will address healthy behaviors and importance of taking prenatal vitamins: vitamins will be provided to pregnant women at no charge.
5. Continue collaboration with Community Health Centers of Lane County in assisting pregnant women to access OHP services.

Evaluation:

1. OMC staff will use electronic medical record system for tracking client information. OMC staff will continue to send data to the state in agreed upon manner.
2. OMC staff will record program outputs and outcomes as part of the countywide performance measure process.
3. Excel spreadsheet will be maintained to track distribution of brochures and other outreach materials. Noted in OMC Program Elements in IGA with DHS.

• **Maternal Child Health, Maternity Case Management (MCM), Babies First!**

Current condition or problem:

1. Lane County's fetal-infant mortality rate is higher than the rate for Oregon and the U.S. The most current data indicates that Lane County's rate has improved (decreased) and is now closer to the Oregon rate (Lane – 8.25; Oregon – 8.0). Initial data continues to indicate that the highest rate of excess death is in the post-neonatal

period (29 days to 1 year of age); and, the second highest excess mortality is related to maternal health and prematurity. Among post neonatal deaths during the two years of fetal infant mortality review, unsafe sleep practices were noted 40% of the time.

2. Collaborative partnerships with health providers and other service agencies have resulted in continued referrals for MCH services.
3. Public Health Nurses (PHNs) provide comprehensive Maternity Case Management (MCM) home visiting services for many women who are at risk of poor pregnancy and birth outcomes.
4. PHNs provide Babies First! services for infants and young children at significant risk of poor health or developmental outcomes.
5. PHNs provide CaCoon services to help families become as independent as possible in caring for their child with special health or developmental needs and help in accessing appropriate services.
6. PHNs provide support and assistance for families who have experienced a child's death by SIDS (Sudden Infant Death Syndrome). The Fetal Infant Mortality Review group case team reviews all fetal/infant deaths.

Goals:

1. Reduce Lane County's unacceptably high rate of fetal-infant mortality.
2. Increase the number/rate of births that are full-term (≥ 37 weeks) and appropriate weight (≥ 6 lbs.)
3. Decrease the number of pregnant women who use alcohol, tobacco, or illicit drugs during pregnancy.
4. Optimize birth and childhood outcomes for at-risk families through education, referral and support.
5. Prevent and mitigate early developmental delays, ensure early intervention of delays that are identified, and optimize each child's potential capacity.
6. Increase family independence in caring for children with special needs.
7. Maintain up-to-date data entry into ORCHIDS.

Activities:

1. Facilitate the community initiative for the reduction of fetal-infant mortality.
2. Work to fund and continue the FIMR (Fetal Infant Mortality Review) process in Lane County.
3. Provide comprehensive, quality MCM nurse home visiting by well-trained and capable PHNs for at risk pregnant teen and adult women. (As noted in Program Element 42 of Oregon Health Authority IGA.)

4. Provide quality Babies First and CaCoon nurse home visiting services by well trained and capable PHNs. (As noted in Program Element 42 of Oregon Health Authority IGA.)
5. Provide nurse home visiting support for families who have experienced a SIDS death. (As noted in Program Element 42 of Oregon Health Authority IGA.)
6. Work closely with WIC to ensure a system of public health services for families in need.
7. Participate in local Commission on Children and Families SB 555 early childhood planning efforts.
8. Ensure staff assigned to do data entry into ORCHIDS for current client data to state. (As noted in Program Element 42 of Oregon Health Authority IGA.)

Evaluation:

1. MCM, Babies First!, and CaCoon data will be recorded in ORCHIDS MDE, the statewide MCH system.
2. MCH referral logs will be maintained to track referrals for MCH services and identify referral sources.
3. PHNs will maintain a case log that indicates the outcome of client contact.
4. PHNs, with the assistance of ancillary staff, will record program outputs and outcomes as part of the countywide performance measure process.

Public Health Emergency Preparedness

Goals, objectives and activities are provided on pages 21 and 22 of this document as well as within the Communicable Disease and Environmental Health Action Plans.

Tobacco Prevention Program Objectives

- By June 2012, Lane County TPEP Coordinator will have partnered with Lane County HC Coordinator and other partners on a minimum of two collaborative efforts (Lane County Worksite Wellness Program Implementation Committee and new ACHIEVE grant) aimed at chronic disease prevention, early detection and self-management that is broader than, but also includes tobacco prevention. By June 2011, TPEP/HC staff will have met with a minimum of 5 local policy makers (outside of the Board of County Commissioners) to share local chronic disease prevalence data and information on local success stories for the purpose

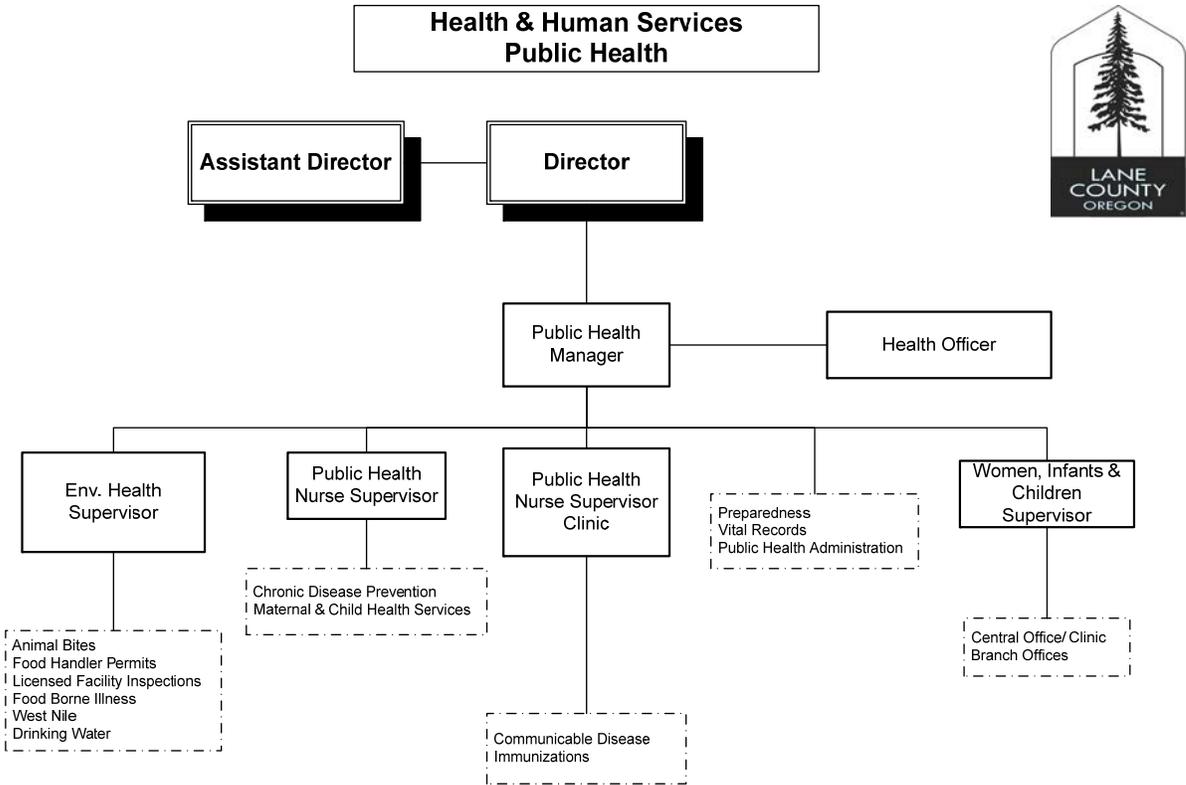
- of increasing general support for the program and assessing political feasibility of future policy work.
- By June 2012, goal is that the remaining Lane County H&HS properties will transition to tobacco-free status and a formal H&HS tobacco-free campus policy will be adopted, incorporated into the Departmental policy manual, and distributed by e-mail to all H&HS staff.
 - By June 2012, establish and implement a regular schedule to conduct tobacco-use environmental assessments at all H&HS properties to ensure compliance with new policy and address problem areas and build champions to continue policy assessment and communication efforts into perpetuity.
 - By June 2012, Lane County Department Directors, Central Administration Office, Human Resources, and Board of County Commissioners/Board of Health will have participated in educational sessions to increase understanding of the importance of adopting a county-wide tobacco-free properties policy.
 - By June 2012, Lane County Public Health will have responded to all complaints of violation of the Smokefree Workplace Law according to the protocol specified in the IGA.
 - By June 2012, the City of Eugene will have made changes to City Code 6.225-6.240 "Tobacco Products and Smoking" that will eliminate or redefine the Tobacco Retail Shop exemption in such a way that it no longer allows for the establishment of smoking lounges.
 - By June 2010, one of the two largest affordable housing providers in Lane County (excluding HACSA, our public housing authority) will have adopted a smokefree housing policy for all agency owned/managed properties. Staff will be working with Metro Affordable Housing Incorporated (419 units) and St. Vincent de Paul (over 1,000 units).
 - By June 2012, Lane Community College will have adopted a revision to its current "Tobacco Free Core Campus" policy that will eliminate designated smoking areas in parking lots, therefore making the campus truly 100% Tobacco Free.
 - By Fall 2012, the University of Oregon will have implemented its Tobacco Free Campus Policy.
 - By June 2012, the City of Eugene will have updated sections of Code 3.500-3.515 pertaining to Tobacco Products Retail Licenses in such a way that an increased licensing fee will cover the costs associated with bi-annual inspections of all tobacco retail outlets and any other subsequent enforcement requirements.

Breast and Cervical Cancer Screening Program – Community Health Centers of Lane County, a division of the Lane County Department of Health and Human Services, has a Medical Services Agreement with Oregon Health Authority/Public Health Division to provide this program in Lane County.

IV. Additional Requirements

1. The organizational chart for Lane County Public Health Services is on the page following SB 555.
2. The Lane County Board of County Commissioners serves as the Board of Health. Minimally, they convene two times per year to receive the Lane County Department of Health and Human Services biannual Board of Health Report. This report includes all divisions of the department, ranging from Public Health to Behavioral Health to Family Mediation. The report is a public document and available to anyone who requests it and is posted on the department's website. In addition, when requested by our Department Director/Health Administrator, the Board of Health convenes on public health policy issues. With the assistance from our County Counsel, the Board of Health has developed better understanding of its authority to pursue and set policy at the local level to ensure improved community health. The Board of Health meetings are public meetings, with notice to the community. The Department Director of Health and Human Services (Health Administrator) reports to the County Administrator and the Board of County Commissioners.
3. Lane County Public Health has an Advisory Committee (PHAC) which meets the second Tuesday evening of each month (5:30 p.m.-7:00 p.m.). The Committee consists of 12 members: seven at-large and five persons licensed by the State of Oregon as healthcare practitioners. Committee members have assisted Lane County Public Health with its five-year strategic plan, the Healthy Babies Healthy Communities Coalition work, chronic disease prevention, and herbicide spraying issues, to name a few. The committee is provided program updates from Public Health staff. In its 2010-2011 annual report to the Board of County Commissioners, to which they are advisory on public health matters, PHAC has identified the following major themes/work: chronic disease prevention (tobacco-free policies for Lane County government, obesity prevention); air quality issues; healthy food choices in area schools; dental health and access to dental health services; and continue review of the impact on changes to Lane Code 18 (Ambulance Service Areas). The PHAC will have its goals-setting session for the next year at its December 2011 meeting.
4. Senate Bill 555: During its last Comprehensive Planning process which ended in early 2008, Lane County prioritized three community focus issues: 1) Increasing effective community supports for Youth in Transition (YIT) with moderate to severe mental health issues; 2) Increasing quality infant toddler child care slots; and 3) Developing strategies to increase our quality and capacity in home visiting programs to reduce child maltreatment. Public Health has played a variety of roles during the planning and implementation phases of the collaborative efforts the community has developed addressing these focus issues. This has included strategic and resource development,

program planning, coordination, networking and community education. Two out of the three focus issues are priorities which grew out of the Early Childhood Planning Team. The focus on home visiting came about as a collaborative effort including the Commission on Children and Families, Public Health, Department of Human Services, United Way, schools and social service agencies, because this strategy has had a positive impact on reducing a community's fetal/infant mortality rate as well as reducing child maltreatment. Public Health will continue to be involved in both the home visiting and youth with mental health needs focus issues.



Public Health Department Structure
Last Update: 03/2011

V. Unmet Needs

As Lane County Public Health Services begins a new fiscal year, our projected budget provides funding at a level of service the same as FY 10/11. In the action plan of this document, we have identified activities which are priorities to meet some of our county's needs. We continue to work on providing mandated services and maintain our local public health authority.

In previous years of reductions, we have had to close the three branch offices for public health (Oakridge, Florence, Cottage Grove). Serving the rural residents of our county with public health services (family planning, immunizations, maternal child health, communicable disease) in their communities continues to be an unmet need. Services continue to be available in the central (Eugene) office, but transportation to Eugene for many of these citizens is problematic. We have been able to continue nurse home visiting throughout the county, although we are not able to take on all the referrals given each month. Limited WIC services in Cottage Grove, Oakridge and Florence continues, however, there are long waits for clients to access these services due to limited number of times per month staff are in the rural areas. Our Environmental Health staff continue to provide inspections of all licensed facilities throughout the county.

The recent publication from the University of Wisconsin on County Health Rankings provided a snapshot view of some of the factors that contribute to the health of Lane County. Our overall ranking of 18 out of 33 counties was not a surprise, since we know the air quality issues we face at the end of the Willamette Valley and our rates of diabetes, obesity, chlamydia and low birth weight babies are significant. We have struggled with supporting a Chronic Disease Prevention Program in order to maintain sustainability, since much policy work needs to be done at the local level if we are to reduce morbidity and mortality related to tobacco use and lack of physical activity and nutrition. Our staff has done amazing work with the state tobacco prevention funding and Healthy Communities funding, however, it will become necessary for us to continue searching for other funding as well in order to address these significant public health issues at a policy level. Strong local community relationships have been built as well as across the state in chronic disease prevention and the need is great to continue the work.

Within MCH and local agencies, we have a strong working relationship and referral process. These agencies continue to support the provision of nurse home visits for high risk families and know that the visits are critical to reducing child abuse and neglect as well as increasing the health of our children. We are able to provide a number of home visits, although the need for more nurses to provide prevention services is greater than the funding allows. There are several referrals each month to our MCH team that cannot be assigned, not because they aren't a high enough risk, but due to insufficient nurse staff to accommodate the increasing need in our community. We are meeting with the Community Health Centers of Lane County management team to look at

funding options under the CHC as well as a stronger referral process into our maternity case management and Babies First! Programs in order to increase our service level.

The largest initiative we have begun has been the concern over the Fetal Infant Mortality rate in Lane County. This has been addressed in other sections of this plan, and it continues to be a priority for our work. A Fetal Infant Mortality Review (FIMR) process continues and has been instrumental in providing the necessary information in order for the coalition to make decisions regarding actions to take that will reduce the mortality rate. We have an active coalition (Healthy Babies, Healthy Communities) working to find the areas to strengthen in our community in order to reduce the mortality rate. As much as we want to continue this effort, we continually look for funding to support the effort as well as funding to establish a Nurse Family Partnership (NFP) model for nurse home visiting as noted above. These two efforts would make a substantial difference to the health and well being of the families and babies we serve.

VI. Budget

The contact person for the approved annual budget for Lane County Public Health is Lynise Kjolberg, Administrative Services Supervisor, Dept. of Health & Human Services. Her phone number is (541) 682-3968; e-mail is lynise.kjolberg@co.lane.or.us. The budget is presented by individual programs and will be submitted to the state per each of the program required timelines.

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. Note: Policies and procedures exist but are not reviewed on an annual basis. We have department and program policies and procedures that are reviewed and updated as needed.

5. Yes No Ongoing community assessment is performed to analyze and evaluate community data. Note: A formal analysis is not done. We do community analysis as needed regarding specific program issues.
6. Yes No Written plans are developed with problem statements, objectives, activities, projected services, and evaluation criteria. Note: As a county and department, we have been writing performance measures and data collection forms. This is an ongoing process.
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. Note: we strive to do this.
14. Yes No Evidence of staff development activities exists. Note: staff note on their electronic time cards all trainings they attend.
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. Note: a review is not completed on an annual basis. Forms are reviewed and updated as needed.

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. Note: records are maintained in a confidential manner.
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. Note: Not reviewed on an annual basis.
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 _X_ Health department administration and county medical examiner review collaborative efforts at least annually. Note: Efforts are not reviewed on an annual basis, but as the need arises. The Public Health Officer works with District Attorney's office as needed to collaborate with the work of the Deputy Medical Examiner.
31. Yes _X_ No ___ Staff is knowledgeable of and has participated in the development of the county's emergency plan.
32. Yes _X_ No ___ Written policies and procedures exist to guide staff in responding to an emergency.
33. Yes _X_ No ___ Staff participate periodically in emergency preparedness exercises and upgrade response plans accordingly.
34. Yes _X_ No ___ Written policies and procedures exist to guide staff and volunteers in maintaining appropriate confidentiality standards.
35. Yes _X_ No ___ Confidentiality training is included in new employee orientation. Staff includes: employees, both permanent and temporary, volunteers, translators, and any other party in contact with clients, services or information. Staff sign confidentiality statements when hired and at least annually thereafter.
36. Yes _X_ No ___ A Client Grievance Procedure is in place with resultant staff training and input to assure that there is a mechanism to address client and staff concerns.

Control of Communicable Diseases

37. Yes _X_ No ___ There is a mechanism for reporting communicable disease cases to the health department.
38. Yes _X_ No ___ Investigations of reportable conditions and communicable disease cases are conducted, control measures are carried out, investigation report forms are completed and submitted in the manner and time frame specified for the particular disease in the Oregon Communicable Disease Guidelines.
39. Yes ___ No _X_ Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or communicable disease case received. (Note: Physician is contacted during investigation and at other times as requested by physician or as indicated by the investigation.)

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. (Note: Available in Lane County, not at Lane County Public Health.)

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. (Note: In Food Handlers Manual-English and Spanish.)
50. Yes No Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided. (Note: Through Red Cross.)
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. Note: Through the Public Works Department, Land Management Division for Lane County.
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. (Note: At request of school districts.)
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. (Note: Through Department of Public Works, Waste Management Division of Lane County.)
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. (Note: Through Lane County Sheriff's Office, HazMat and Public Health.)

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. (Note: In coordination with Department of Public Works, Department of Environmental Quality and State Water Program, Public Health.)

66. Yes No All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448. (Added per G.S. request, not in program indicators)

Health Education and Health Promotion

67. Yes No Culturally and linguistically appropriate health education components with appropriate materials and methods will be integrated within programs.

68. Yes No The health department provides and/or refers to community resources for health education/health promotion.

69. Yes No The health department provides leadership in developing community partnerships to provide health education and health promotion resources for the community.

70. Yes No Local health department supports healthy behaviors among employees.

71. Yes No Local health department supports continued education and training of staff to provide effective health education.

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

Nutrition

73. Yes No Local health department reviews population data to promote appropriate nutritional services. (Note: Within TROCD grant our PHE looks at BMI community data and BRFS)

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. Note: Contact Lane County Senior Services.

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. (Note: Information and referrals are provided to the public when requested. LCPHS does not provide services directly.)

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. (As of July 1, 2006, Family Planning is now provided through the Federally Qualified Health Center within the Department of Health and Human Services.)

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. (Note: Supervisor member of MDT.)
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. (Note: Provided through referral only. Community Health Nurses discuss the importance of good oral health, prevention, and nutrition during home visits.)
91. Yes No Use of fluoride is promoted, either through water fluoridation or use of fluoride mouth rinse or tablets. (Note: MCH nurses talk with families about importance of dental care and fluoride rinse and varnishes.)
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. (Note: By referral only) The Community Health Centers of Lane County in the H&HS Department has been a partner with us and

a valuable referral for the uninsured, underinsured and those with Medicaid and insurance coverage.

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. Note: LCPHS is developing performance measures and data collection processes.

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. (Note: This is limited information, utilizing Lane Council of Governments information and through the U.S. Census and Portland State University information.)
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. (Note: Within the county and department documents.)
101. Yes No The local health department assures that advisory groups reflect the population to be served. (Note: this is our goal, however the recruitment process often doesn't provide a cross section of individuals.)
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: Karen Gaffney, Interim Director

Does the Administrator have a Bachelor degree: Yes No

Does the Administrator have at least 3 years experience in public health or a related field? Yes No

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

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

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

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

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

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

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

b. Yes No The local health department Supervising Public Health Nurse meets minimum qualifications: (yes, Betsy Meredith)

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.

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

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

OR

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

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

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

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

County

Date

Immunization Annual Plan - Fiscal Year 2012-2013

Local Health Department: Lane County

Plan A - Continuous Quality Improvement: Increase up-to-date rate and decrease missed shot rate

July 2012 – June 2013						
-Objectives	Activities	Date Due / Staff Responsible		Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p>A. Increase the up-to-date rate for 2 yr olds seen at Lane County Public Health by 1% over the next yr.</p> <p>B. Decrease the missed shot rate by 1% at Lane County Public Health over the next year.</p>	<p>Use most recent AFIX assessment data as baseline</p> <p>Devote time at team meeting twice this year to staff review of immunization procedures including vaccine updates, current standards, true contraindications, catch-up schedule, parent education, ways to improve practice.</p>			<p>Review as soon as report sent by OIP.</p> <p>Immunization review at team meeting in April and Sept.</p>	To be completed for the CY 2012 Report	To be completed for the CY 2012 Report

	<p>Amend activities in Oct 2011 after assessing results of 2010 and 2011 activities.</p> <p>Staff discussions on 1) attention to forecasting 2) assuring vaccine stock available for each vaccine 3) providing parent education and resources for information on recommended immunizations.</p> <p>Reminder/recall letters to parents of age 36 mos and under who are due or past due for vaccines. This will pick up those due for DTaP4 (focus for improvement).</p>			<p>Update plan by Nov 1, 2011.</p> <p>Discussions held at CD team meeting Sept and Jan. Using parameters of new IIS assess “reasons not given”, especially “out of stock” and “not forecasted” on quarterly basis.</p> <p>Run report from ALERT IIS for age 36 mos and under quarterly beginning Jan 2012. Send letters to parents to encourage appts. to get vaccines.</p>	<p>To be completed for the CY 2012 Report</p>	<p>To be completed for the CY 2012 Report</p>
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Local Public Health Authority Immunization Annual Plan Checklist
July 2012-June 2013
Lane County Health Department

LHD staff completing this checklist: Martha deBroekert RN, Immunization
Coordinator, and Betsy Meredith RN, supervisor

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:**

Will plan activity around vaccine hesitancy/religious exemptions (Activity 1)

will plan an activity for provider education (Activity 2)

(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: 4th 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.

Q. 44 This is based on AFIX 2010 report. Our triennial plan objective A addresses increasing the up-to-date rate and decreasing the missed shot rate. We see a very small number of kids and a different population each year so consistency in our efforts doesn't always change our stats. See attached plan.

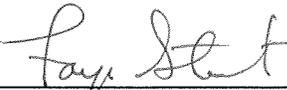
Q.

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

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

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	Lane	November 30, 2011
Local Public Health Authority	County	Date