

**LINN COUNTY DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH PROGRAMS**



**ANNUAL PLAN
2013-2014
COMPREHENSIVE**

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I. EXECUTIVE SUMMARY

The Annual Plan submitted for FY 2013-2014 for Linn County includes an assessment conducted in 2011-2012 which includes demographic and public health indicators for Linn County; a description of the delivery of local public health services; action plans for the delivery of the core public health services; and an update of unmet needs. Last year's annual plan was a comprehensive plan and new assessment numbers have not been added since it was completed in March of 2012. Over the past year, Linn County Public Health has been working on accreditation readiness and completed our [Community Health Assessment](#), [Community Health Improvement Plan](#) as well as our [Strategic Plan](#). These documents may be viewed at [Linn County Public Health Website](#).

The Linn County Community Health Improvement Plan represents a year of work in which the County and its partners utilized the Mobilizing Action through Planning and Partnerships(MAPP) framework to assess the health status of the county and build a plan to improve priority areas. Four Key topic areas were prioritized by the MAPP committee based on collected health statistics, survey data, and key informant interviews. These areas include Access to Health Care, Tobacco Use, Chronic Diseases, and Substance Abuse. This document has shared ownership across all partners of Linn County Public Health and has shared responsibility in achieving goals.

The strategic plan for Linn County Public Health (LCPH) was drafted in March 2012 to guide Linn County Public Health Program leadership and staff over the next three years as they work together to deliver quality, countywide Public Health services to the Linn County community. LCPH's strategic focus is based on goals found in the following four Strategic Priority Categories:

- Infrastructure-There are staff and Linn County partnership resources that address emerging Linn County Public Health concerns
- Financial Sustainability-Assured financial viability of all Linn County Public Health programs
- Access/Quality of Care-Increased awareness of Public Health services
- Community and Partners-Programs are focused on improving community public health outcomes.

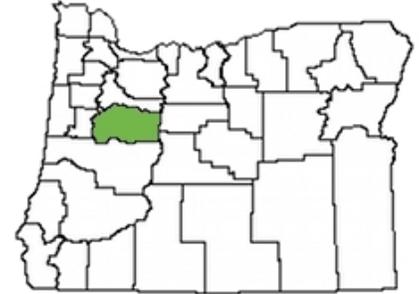
The challenge is to continue to move forward and advocate for Linn County Public Health to be a key player in local health transformation. Recently, there have been productive meetings with the local Coordinated Care Organization (CCO) for our area in discussing how public health fits into the health reform. Our focus on prevention will help address certain indicators that continue to be a concern in our county. The leading causes of preventable death in our county continue to be tobacco use, obesity and inactivity. Linn County Public Health continues to provide the 5 essential services required by Oregon law to meet the health needs of the community.

II. ASSESSMENT

A comprehensive Linn County Community Health Assessment was released in June 2012. The full [Community Health Assessment](#) can be found on the [Linn County Public Health Website](#).

Demographics

Linn County is located in the center of Oregon’s Willamette Valley. The county is 2,310 square miles and spans from its western boundary, the Willamette River, across to the top of the Cascade Mountain range. The climate and soils in Linn County create ideal agricultural conditions; the county produces a variety of specialty crops and is the nation’s leader in grass seed production.



Population

Since 2000, Linn County has experienced a 13.2% population increase¹. According to the 2010 US Census, the population of Linn County is 116,672¹. The population density in Linn County is 51 people per square mile¹. Because the county is an agriculturally driven community, there are proportionately more people living in rural areas compared to the state in general. It is estimated that 37% the Linn County’s population resides in a rural location while only 21% of Oregon lives in a rural setting².

	Linn County	Oregon
Population	116,672	3,831,074
Population change, 2000 to 2010	+13.2%	+12.0%
Land Area	2,292 square miles	95,997 square miles
Population density	51 people per square mile	40 people per square mile
*Percent of population living in a rural location	37%	21%
Female population	50.5%	50.4%

Source: US Census Bureau-*State and County QuickFacts: Linn County, Oregon, 2010*

*County Health Rankings- *Linn County, 2011*

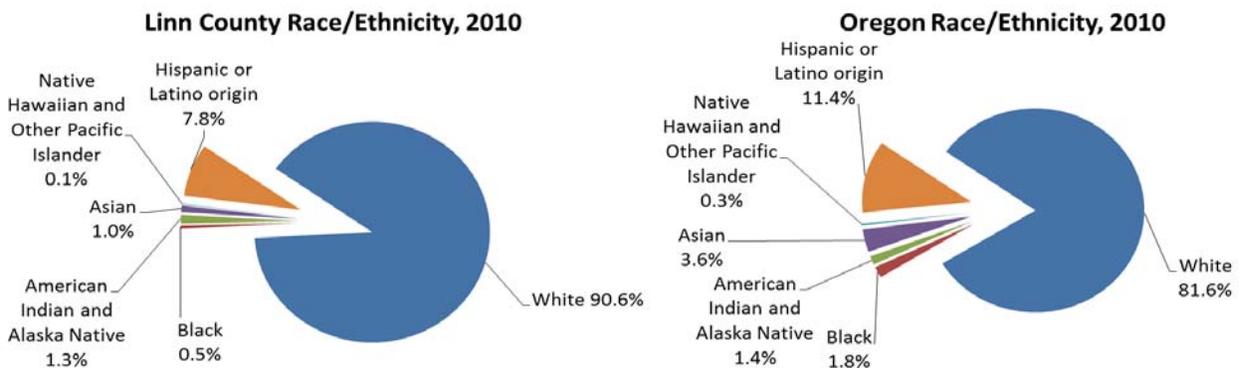
Linn County has a greater percentage of its population over age 65 compared to the total population of Oregon. In Linn County, 15.9% of the population is over 65; the number of people over 65 in the state of Oregon is 13.5%¹. The percent of Linn County between the ages of 19-64 is 53.6%; this is lower than Oregon where 57.2% of the population is between 19-64^{Error! Bookmark not defined.}. About 6.6% of the County is under age 5 and 22.8% of the population is between the ages of 5-18; these numbers are right in line with Oregon’s.

¹ US Census Bureau (2011) *State and County Quick Facts: Linn County, OR* Retrieved 20 September 2011 from <http://quickfacts.census.gov/qfd/states/41/41043.html>

² County Health Rankings (2010) *Snapshot: Linn County Oregon*. National Vital Statistic System, Centers for Disease Control and Prevention. Retrieved 21 September 2011 from <http://www.countyhealthrankings.org/oregon/linn>

Race/Ethnicity

In Linn County, the majority of the population is White. According to the 2010 US Census, Linn County is 90.6% White, 7.8% Hispanic or Latino, 1.3% American Indian or Alaskan Native, 1.0% Asian, 0.5% Black, and 0.1% Hawaiian or Pacific Islander¹. In Oregon, the majority of the population is also White. The Oregon Population is 81.6% White, 11.4% is Hispanic or Latino origin, 3.6% Asian, 1.8% Black, 1.4% American Indian or Alaskan Native, and 0.3% Native Hawaiian or Pacific Islander.



Source: US Census Bureau-*State and County QuickFacts: Linn County, Oregon, 2010*

Socioeconomic Characteristics

In Linn County, the median household income is \$46,717³. This sits below Oregon's median household income of \$48,325⁴. The average household size in Linn County is 2.56 people and the average family size is 3.05 people⁵.

The unemployment rate in Linn County is higher than the overall rate in Oregon. According to the Oregon Employment Department, 11.9% of Linn County was unemployment in August 2011⁶. The unemployment level in Oregon during August 2011 was 9.6%⁶.

The number of people in Linn County living at or below poverty level is slightly higher than Oregon. Approximately 14.9% of Linn County lives at or below poverty level and an estimated 19.7% of individuals under the age of 18 live at or in poverty⁷. In Oregon 14.3% of the population lives at or below poverty level and so does 19.4% of the population under the age of 18⁷.

³ US Census Bureau (2011) *Selected Social Characteristics: 2005-2009: 2005-2009* Retrieved 20 September 2011 from http://factfinder.census.gov/servlet/ADPTable?_bm=y&-geo_id=05000US41043&-qr_name=ACS_2009_5YR_G00_DP5YR2&-ds_name=&-lang=en&-redoLog=false

⁴ US Census Bureau (2011) *Selected Social Characteristics: 2005-2009: 2005-2009* Retrieved 20 September 2011 from http://factfinder.census.gov/servlet/ADPTable?_bm=y&-geo_id=05000US41043&-qr_name=ACS_2009_5YR_G00_DP5YR2&-ds_name=&-lang=en&-redoLog=false

⁵ US Census Bureau (2011) *Selected Social Characteristics: 2005-2009: 2005-2009* Retrieved 20 September 2011 from http://factfinder.census.gov/servlet/ADPTable?_bm=y&-geo_id=05000US41043&-qr_name=ACS_2009_5YR_G00_DP5YR2&-ds_name=&-lang=en&-redoLog=false

⁶ Oregon Unemployment Department (2011) *Current Unemployment Rates*. Retrieved 7 October 2011 from <http://www.qualityinfo.org/olmisi/AllRates>

⁷ U.S. Census Bureau (2009) *Small Area Income and Poverty estimates- Linn Count*. Retrieved 7 October 2011 from <http://www.census.gov/cgi-bin/saiper/saiper.cgi>

Educational Attainment

In Linn County, the high school graduation rate is 70%; the Oregon high school graduation rate is 74%². Graduation rate is considered the number of ninth graders in public schools who graduate from high school in four years.

Education level for people 25 and older , 2005-2009	Linn County	Oregon
*High School Graduation Rate	70%	74%
Less than high school degree, no diploma	13.8%	11.8%
High school graduate (or equivalency)	33.1%	26.0%
Some college, no degree	29.1%	26.1%
Associate's degree	8.4%	8.0%
Bachelor's degree	10.9%	18.1%
Graduate or professional degree	4.8%	10.2%

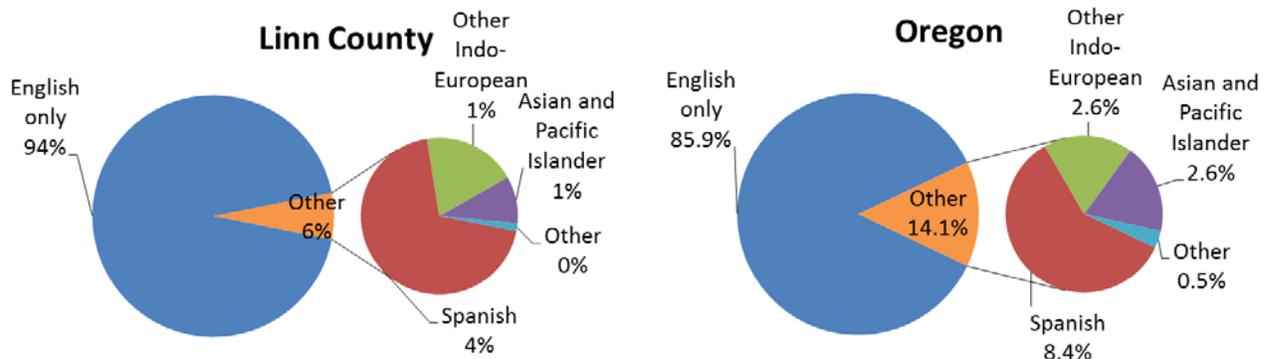
Source: US Census Bureau-State and County QuickFacts: Linn County, Oregon, 2010

Linn County has fewer residents over the age of 25 with a high school diploma and college degree compared to the rest of Oregon. In Linn County, 86.2% of the population over age 25 have received a high school diploma; in Oregon 88.3% of the population have received high school diplomas¹. Only 15.6% of Linn County residents over age 25 have received a bachelor's degree compared to 28.3% of Oregon¹.

Language

According to the 2005-2009 US Census Bureau data, 6.8% of Linn County residents speak a language other than English in their home. Of the non-English speaking households, 4.3% speak Spanish, 1.2% speak a form of Indo-European language, 0.6% speak Asian or Pacific Island language, and 0.1% speak other languages⁵.

Source: US Census Bureau- Selected Social Characteristics: 2005-2009



Health Resource Availability

	Linn County	Oregon
Uninsured children, 2010	10.8%	10.6%
*Uninsured Adults, 2010	19%	21%

Source: Oregon Department of Human Services: Children First For Oregon, 2010
County Health Rankings: Linn County, 2010

Health insurance coverage remains an area of concern in Oregon and Linn County. Approximately 10.8%⁸ of Linn County children are uninsured and 19%² of adults are not insured. In Oregon on a whole 10.6%²² of children and 21%²³ of adults are uninsured.

In Linn County, there are two hospitals with 88 short-term general hospital beds². There are approximately 69.8 primary care physicians and 30.9 dentists per 100,000 population². About 83.4% of adults have someone they consider their own personal doctor; in Oregon, only 79.6% of adults have a personal doctor⁹.

Linn County Public Health continues to partner with Samaritan Health Services In-Reach clinic and Community Outreach, INC donating clinic space, supplies, and electronics for a weekly free clinic in both Albany and Lebanon.

There are no school based health clinics in Linn County. Throughout Oregon, there are a total 53 certified health clinics operating within schools⁸.

Childhood Health Indicators

	Linn County	Oregon
Entrance into prenatal care by 1st trimester, 2010	96.2%	94.7%
Teen pregnancy per 1,000 girls (ages 15-17), 2010	21.4	20.8
Infant mortality per 1000 live births, 2010	8.4	4.8
*Children living in single parent households, 2005-2009	32%	29%
*Low birthweight, 2001-2007	6.2%	6.0%
Percent of 2 year olds up to date with immunizations	57.8%	70.3%
Child Obesity rate	27.4%	26.8%
Abuse and neglect victims (per 1,000 ages 0-17), 2010	12.3	7.3

Source: Oregon Department of Human Services: Children First For Oregon, 2010
*County Health Rankings: Linn County, 2010

⁸ Children First for Oregon (2010) *Linn County*. Oregon Department of Human Services Center for Health Statistics. Retrieved 21 September 2011 from http://www.cfo.org/images/pdf_downloads/county_data_books/Linn%20County.pdf

⁹ Oregon Health authority (2011) *Adults who have someone they consider their own personal doctor, Oregon, 2006-2009*. Retrieved 20 October 2011 from <http://public.health.oregon.gov/BirthDeathCertificates/Surveys/AdultBehaviorRisk/county/index/Documents/hcaowndocnaa.pdf>

The percent of pregnant women in Linn County who obtain early prenatal care is high. Approximately 96.2% of pregnant women obtained prenatal care by the 1st trimester, which this is slightly better than the Oregon rate of 94.7%⁸.

While the number of pregnant women receiving prenatal care is high, childhood health is an area of concern in Linn County.

The teen pregnancy rate in Linn County for girls ages 15-17 is 21.4 per 1,000 females age 15-17 from 2009 live births; slightly higher than Oregon's teen pregnancy rate of 20.8 per 1,000 live births².

Approximately 32% of children in Linn County live in single parent households, compared to the overall Oregon Rate of 29%².

The infant mortality rate in Linn County is nearly twice as high as Oregon's. In 2010, the Linn County infant mortality rate was 8.4 deaths per 1,000 live births². In Oregon, the rate was 4.8 per 1000 live births. In Oregon and Linn County, approximately 6% of babies have a low birth weight (less than 2,500 grams)².

Immunization rates throughout Oregon could improve. In Linn County, only 57.8% of 2 year olds were up to date with their immunization series in 2010². Oregon's immunization rate was higher at 70.3%².

In Linn County there are almost twice as many child abuse and neglect victims reported in a year compared to the state. In 2010, the rate of abuse and neglect in Linn County among children under the age of 17 is 12.3 per 1000 children². In Oregon, 7.3 per 1,000 children are victims of abuse and neglect².

In Linn County public schools, 52.3% of public school kids are eligible for either free or reduced lunches¹⁰.

In Linn County, 27.4% of children are considered obese, slightly higher than the state average of 26.8%¹⁰.

Quality of Life

Over the last two years, County Health Rankings has used data obtained from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) and the CDC's National Vital Statistic System to compile the County Health Rankings. This document is a key component of the Mobilizing Action toward Community Health (MATCH) project. MATCH is a collaborative effort between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

¹⁰ Children First for Oregon (2010) *Linn County*. Oregon Department of Human Services Center for Health Statistics. Retrieved 21 September 2011 from http://www.cffo.org/images/pdf_downloads/county_data_books/Linn%20County.pdf

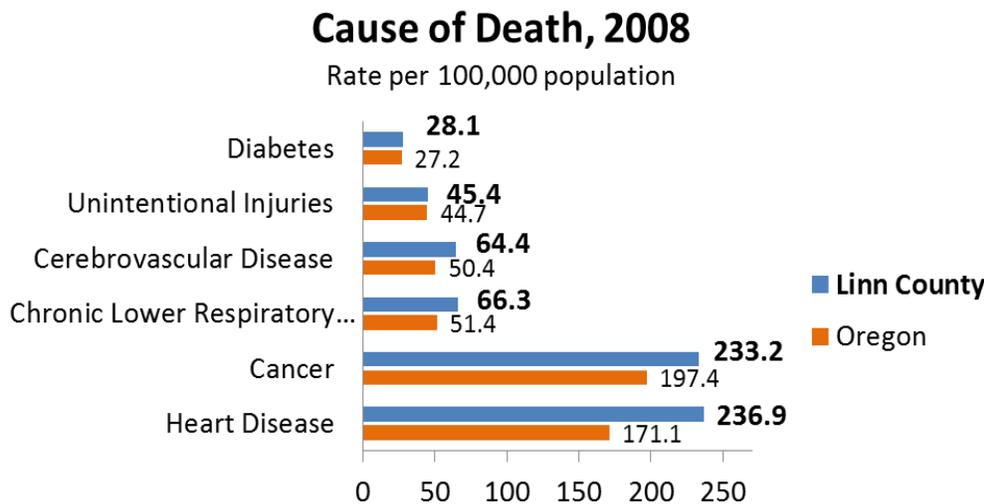
The most recent data from County Health Rankings published in 2011 ranks Linn County 28th out of 33 Oregon Counties in overall health outcomes². Health outcomes are measured on factors of mortality and morbidity.

Mortality

Linn County is ranked 23rd out of 33 Oregon counties for mortality measures². Mortality is measured by a rate of premature death, factored with the common statistical measurement of years of potential life loss, (YPLL). YPLL is used to factor the frequency and distribution of death before the age of 75, which is considered a premature death. Linn County has a premature death rate of 7,952 per 100,000 population, compared to Oregon’s rate of 6,478².

Causes of Death

In 2008, the leading causes of death in Linn County were Heart Disease (23.2%), Cancer (22.8%), Respiratory Disease (6.5%), Cerebrovascular Disease (6.3%), Unintentional Injuries (4.4%), and Diabetes (2.6%)¹¹. Other causes of death are reported among the county and state¹¹.



Source: Oregon Health Authority, *Leading causes of death by county of residence, 2008*

In Linn County the rate of death from Cancer and Heart Disease is concerning. In 2008, the rate of death from Heart Disease in Linn County was 236.9 per 100,000 population; In Oregon the rate of death from Heart Disease was 171.9. per 100,000¹¹. The rate of death from cancer in Linn County is 233.2 per 100,000 and in Oregon, it is 197.4 per 100,000¹¹.

¹¹ Oregon Health Authority (2008) *Leading causes of death by county of residence, Oregon 2008*. Retrieved 21 November 2011 from http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/CountyDataBook/cdb2008/Documents/tb18_08.pdf

Morbidity

	Linn County	Oregon
Premature Death	7,755	6,537
Living in Poor Health	18%	14%
Days in poor Physical Health	4.5	3.6
Days in Poor Mental Health	4.0	3.3

Source: County Health Rankings: Linn County, 2010

In terms of morbidity, Linn County ranks 29th out of 33 Oregon counties². Morbidity attempts to explain the quality of health experienced by the living population. County Health Rankings specifically reports on measures pertaining to physical, mental, and overall health. Approximately 18% of Linn County residents report living in poor to fair health and 17% report inadequate social support¹². Another 8% have had least one major depressive episode over the last 30 days¹². Linn County residents report living an average of 4.5 days a month in poor physical health, and an average of 4.0 days in poor mental health².

This is in contrast to 14% of Oregon adults who report living in poor to fair health and only experience 3.6 days a month in poor physical health and 3.3 days a month in poor mental state².

Chronic Disease

Adult Disease Rate 2006-2009	Linn County	Oregon
Arthritis	29.5%	25.8%
Asthma	10.5%	9.7%
Heart Attack	4.5%	3.3%
Coronary Heart Disease	5.0%	3.4%
Stroke	3.7%	2.3%
Diabetes	7.9%	6.8%
High Blood Pressure	27.7%	25.8%
High Cholesterol	29.6%	33%

The rate of chronic disease in Linn County in some incidences exceeds Oregon State average rates. Arthritis, high blood pressure, and stroke are the highest incidence markers for chronic disease in Linn County. Approximately 29.5% of county residents

¹² Oregon Health Authority (2011) *Linn County's Epidemiological Data on Alcohol, Drugs and Mental health 2000-2010*. Retrieved 20 September 2011 from <http://www.oregon.gov/DHS/addiction/ad/main.shtml>

are living with arthritis in comparison to the average state rate of 25.8%¹³. Around 27.7% of the county has high blood pressure and 29.6% have high cholesterol; state rates are 25.8% and 33% respectively¹³. Approximately 10.5% of the population has asthma; the rate of asthma in Linn County is similar to the overall state rate¹³. Almost eight percent of Linn County residents have diabetes; the state average is 6.8%¹³. The rate of heart attack, coronary heart disease, and stroke in the county is 4.5%, 5%, and 3.7% respectively¹³.

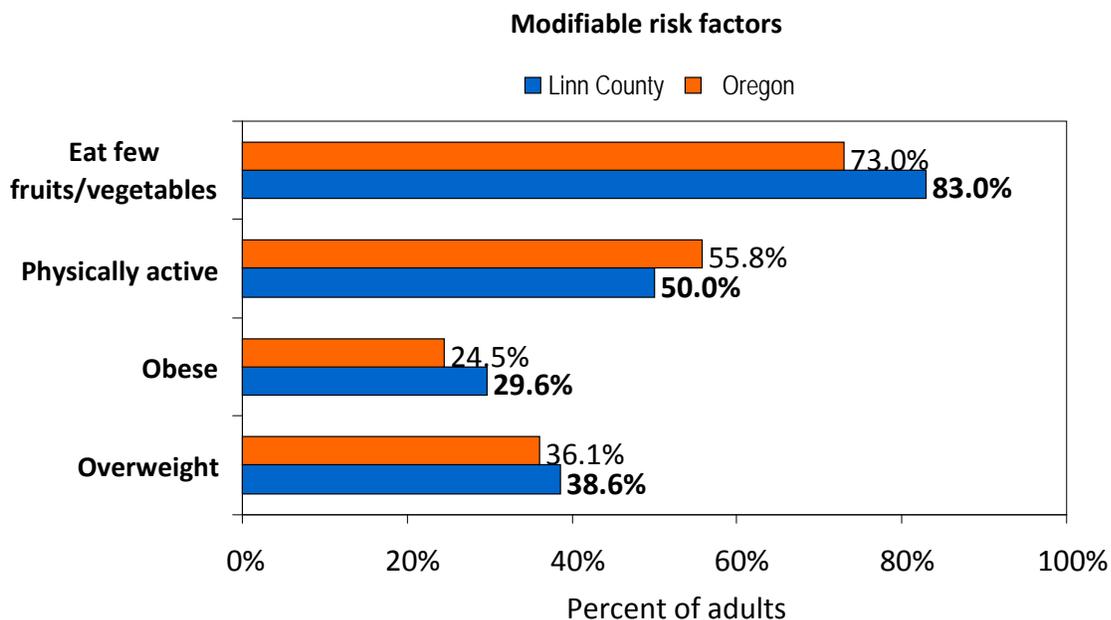
Modifiable Behavioral Risk Factors

Prevention is a core value in public health. The majority of prevention and health promotion programs and models are adopted and implemented to prevent chronic disease. Tobacco use, alcohol consumption, obesity, lack of proper physical activity, and poor dietary habits contribute to the onset of chronic disease.

Physical Health and Nutrition

Perhaps the most profound data in the chart is related to fruit and vegetable consumption. In Linn County 83% of adults, report eating less than five fruits and vegetables per day¹³.

In Linn County, about 30% of Linn County adults are considered obese and 38.4% of adults are considered overweight¹³. In Oregon, about 25% of the adult population is considered obese and 36.1% overweight¹³. Only 51.6% of adults in the county meet the CDC recommendations for physical activity compared to 56% of Oregon adults¹³.

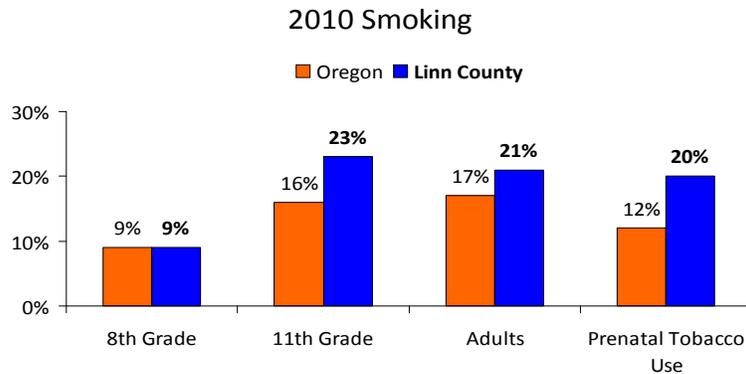


¹³ Oregon Health Authority (2011) *Age-adjusted and unadjusted prevalence of selected chronic conditions among adults, by county, Oregon 2006-2009*. Retrieved 20 October 2011 from <http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/Table1.pdf>

Tobacco

Tobacco use is a problem in Linn County. The Tobacco Prevention and Education Program (TPEP) releases information about tobacco use in each Oregon County. According to the 2010 tobacco fact sheet, 21% of Linn County adults smokes tobacco, compared to the statewide average of 17%.

Around 9% of county 8th graders and 23% of 11th graders smoke cigarettes¹⁴. In Oregon, 9% of 8th graders and only 16% of 11th graders report smoking cigarettes¹⁴.



Source: Oregon Department of Human Services *Linn County Tobacco Fact Sheet*,

Since 1996, the percent of infants born to mothers in Oregon who use tobacco has decreased 34%¹⁴.

Despite this significant decrease, there are an astonishing number of infants born to mothers who smoke in Linn County. Approximately 20% of pregnant women use tobacco while pregnant; this number is much different from the overall Oregon average of 12%¹⁴.

Motor Vehicle Accidents

In Linn County, the death rate from motor vehicle accidents is almost double the state rate. In 2010, the county had a motor vehicle death crash rate of 21.1 crashes per 100,000 population¹². In Oregon, the motor vehicle crash death rate was 14 crashes per 100,000 individuals¹². Only 30% of Linn County crash fatalities involved alcohol while 37% of vehicle fatalities in Oregon involve alcohol¹².

Motor vehicle crash death rate (per 100,000)
Linn County: 21
Oregon: 14

Motor vehicle fatalities involving alcohol
Linn County: 30%
Oregon: 37%

Source: Oregon Health Authority-Linn County's
Epidemiological Data on Alcohol, Drugs and Mental health, 2000-2010

Alcohol

Alcohol consumption negatively affects many human organ systems. It is linked to certain types of cancer and is the leading cause of chronic liver disease.

Alcohol use, especially binge drinking, results in negative health consequences and contributes to motor vehicle crashes, birth defects, and a number of other chronic and acute conditions¹². Binge drinking is considered five or more drinks by men or four or more drinks by women in a short time span. 14% of Linn County adults are considered binge drinkers, which is the same as the overall rate in Oregon¹².

¹⁴ Oregon Department of Human Services (2011) *Linn County Tobacco Fact Sheet 2011*. Tobacco Prevention and Education Program. Retrieved 8 March 2011 from <http://www.oregon.gov/DHS/ph/tobacco/docs/countyfacts/linnfacs.pdf>

Unfortunately, young people who consume alcohol are more likely to binge drink than adults are¹². Young binge drinkers are much more likely to engage in risky behaviors such as drug use, risky sexual behavior, and aggressive antisocial behavior. In 2010, approximately 9% of 8th graders in Linn County and Oregon reported binge drinking¹². During the same year 26% of Linn County 11th graders reported binge drinking; this is higher than 21% of 11th graders throughout the state¹².

Drug Use

An important area of focus in public health revolves around substance use. Drug use affects families, schools, workplaces, and the community. Misuse drugs can lead to long-term health problems and premature death. It can also contribute to injuries, abuse and violence.

In Linn County, the rate of death from drug-induced causes is 12 people per 100,000 populations¹². The state rate is slightly higher; approximately 14 people per 100,000 population die from drug related causes¹².

Marijuana

Marijuana use is common in Linn County and throughout the state of Oregon. The use of marijuana can be addicting and cause adverse physical, mental, emotional, and behavioral changes. Adverse health effects include respiratory illnesses, memory impairment, and weakening of the immune system¹².

Marijuana use is highest among individuals between the ages of 18 to 25. According to the 2006-2008 National Survey on Drug Use and Health, about 18% of Linn County and 20% Oregon residents from ages 18 to 25 use marijuana¹². In Linn County 7% of adolescents between ages, 12 to 17 use marijuana as well as 5% of adult residents over age 26¹². Approximately 8% of Oregon youth between 12 and 17 years of age and 6% of Oregonians over the age of 26 are marijuana users¹².

The most current information regarding youth marijuana use is from 2010. According to information gathered from the Oregon Healthy Teens Survey and the Oregon Student Wellness survey, 10% of Linn County 8th graders and 12% of Oregon 8th graders reported using marijuana in the past 30 days¹². A higher portion of youth in 11th grade reported using marijuana. In Linn County over 1 in 4 students in 11th grade used marijuana¹². Nearly 26% of 11th grade students in Linn County used marijuana one or more times in the last 30 days¹². In Oregon 24% of the 11th grade population used marijuana¹².

Preventative Screening

Preventative screening rates in Linn County are in line with the state rates. In Linn County, 68.1% of the population has had their blood cholesterol checked within the past

5 years; this rate is slightly lower than 71.3% of the state¹⁵. About 77.4% of women ages 50-75 in Linn County have had a mammogram in the past 2 years; the state mammogram screening rate is 82%¹⁵. Women in Linn County between the ages of 18-65 who went in for a PAP smear within the past 3 years is 83.3%¹⁵. This is slightly lower than the state rate for PAP smears, which is 85.8%¹⁵. Colon cancer screening rates in Linn County are slightly higher than the state rate. About 58% of Linn County is screened for colon cancer and around 56.8% of Oregon¹⁵. Approximately 68% of Linn County residents over the age of 65 received a flu shot; the average number of Oregonians accessing this preventative service is 69.2%¹⁶.

Preventative health screening rates, 2006-2009	Linn County	Oregon
Cholesterol checked within past 5 years (18+)	68.1%	71.3%
Mammograms (40+)	77.4%	82.0%
PAP smears (ages 18-64)	83.3%	85.8%
Colonoscopy/sigmoidoscopy (50+)	57.9%	56.8%
Adults 65+ who had a flu shot within the past year	68.6%	69.2%

Source: Oregon Health Authority

Sexually Transmitted Infections

Linn County sexually transmitted disease total counts						
	2005	2006	2007	2008	2009	2010
Chlamydia	194	250	278	315	316	359
Gonorrhea	24	28	29	27	29	35
Syphilis	0	2	1	0	0	0

Source: Oregon Health Authority: Oregon STD statistics

An increased incidence of sexually transmitted infections is a concern in Linn County. The number of Chlamydia cases has steadily increased over the past 5 years. In 2005 the county reported 194 Chlamydia cases; by 2010 the annual number of Chlamydia cases in Linn County reached 359¹⁷. The rate of Gonorrhea has also increased in the county. In 2005, 24 cases of gonorrhea were reported. Thirty-five cases were reported in 2010¹⁷.

Criminal Offenses and Arrests

Every year the Oregon Law Enforcement Agency compiles a report of criminal offenses and arrests of Crimes Against Persons, Crimes Against Property and Behavioral Crimes.

Crimes Against Persons are criminal offenses where the victim is present and the act is violent, threatening or has the potential of being physically harmful. Examples of crimes

¹⁵ Oregon Health Authority (2011) *Age-adjusted and unadjusted prevalence of preventive health screening among adults, by county, Oregon 2006-2009*. Retrieved 20 October 2011 from <http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/TableIII.pdf>

¹⁶ Oregon Health Authority (2011) *Adults 65+ who had a flu shot within the past year, Oregon 2006-2009*. Retrieved 20 October 2011 from <http://public.health.oregon.gov/BirthDeathCertificates/Surveys/AdultBehaviorRisk/county/index/Documents/immfluNAA.pdf>

¹⁷ Oregon Health Authority(2011) *Oregon STD statistics*. Retrieved on October 10, 2011 from <http://public.health.oregon.gov/PreventionWellness/SafeLiving/SexuallyTransmittedDisease/Pages/annrep.aspx>

against persons include willful murder, negligent homicide, forcible rape, other sex crimes, kidnapping, robbery, aggravated assault, and simple assault. In 2009, Linn County had the 11th highest rate in Oregon for crimes against people, a total of 1,130; this equates to a county rate of 101.9 per 10,000 population¹⁸. This is slightly higher than the average rate in Oregon, which sits at 95.4 crimes per 10,000 population¹⁸. Crimes Against Property are criminal offenses that involve taking something of value by theft, deception or the destruction of property¹⁸. Examples of property crimes include burglary, larceny, motor vehicle theft, arson, forgery, fraud, embezzlement, stolen property offenses, or vandalism. Linn County reported 5,234 crimes against property in 2009. This is the 7th highest rate in Oregon at a rate of 472.1 crimes per 10,000 population. The average rate in Oregon is 460 per 10,000 population¹⁸.

	Linn County	Oregon
Crimes against persons	101.9	95.5
Crimes against property	472.1	460
Behavioral crimes	791.1	400.1

Source: Oregon Uniform Crime Reporting- State of Oregon report of criminal offenses and arrests, 2009.

In 2009 Linn County had the second highest behavior crime rate in Oregon¹⁸. Linn County reported 8,777 behavior crimes. This is an annual rate of 791.7 crimes per 10,000 population¹⁸. The state average is 400.1 crimes per 10,000 population. Behavioral Crimes are crimes that represent society's prohibitions on engaging in certain types of activity, such as criminal offenses that violate laws relating to personal conduct, responsibility and public order¹⁸. Behavioral Crimes may not necessarily be violent or property offenses in themselves; however, they may often contribute to other criminal acts.

Cancer Rates

The cancer rate in Linn County is slightly lower than the overall cancer rate in Oregon. Linn County has a cancer rate of 461 per 100,000 individuals, the state rate is 481.5¹⁹. Prostate cancer in males and breast cancer in females are the two forms of cancer with the highest prevalence in Linn County and in Oregon. The prostate cancer rate of 149.9 per 100,000 population and breast cancer rate of 127.9 per 100,000 population in Linn County are slightly lower than the state rates¹⁹. Colorectal and lung cancer are two other forms of cancer with high prevalence rates in Linn County. The county lung cancer rate of 73.5 and colorectal cancer rate of 50 per 100,000 population is slightly higher than the state rate of 70.3 and 48.5, respectively¹⁹. Linn County has lower cancer rates than Oregon per 100,000 population for bladder cancer (22.8), uterine cancer (20.3), lymphoma (20.2), melanoma (18.7), leukemia (10.1), thyroid cancer (6.8), cervical cancer (6.3), and liver cancer (4.3)¹⁹. The rate of brain cancer (7.5), esophageal cancer (5.6), oral/pharyngeal cancer (11.3), pancreatic cancer (10.8), and stomach (5.8) are fairly in line with the state averages¹⁹. Kidney cancer rates (13.5) and ovarian cancer

¹⁸ Oregon Uniform Crime Reporting (2011) State of Oregon report of criminal offenses and arrests 2009. Retrieved 20 October 2011 from http://www.oregon.gov/OSP/CJIS/docs/2009/2009_ANNUAL_REPORT.pdf

¹⁹ Oregon State Cancer Registry (2009) Cancer in Oregon, 2006. Retrieved on 21 October 2011 from <http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Cancer/oscar/arpt2006/Documents/ar06.pdf>

rates (15.2) per 100,000 are slightly higher than state rates of 12.2 and 14.1 per 100,000, respectively¹⁹.

	Linn County	Oregon
All Cancer	462.1	481.5
Bladder	22.8	23.5
Brain/CNS	7.5	7.3
Breast Cancer (females)	127.6	139.8
Cervical	6.3	7.4
Colorectal	50	48.5
Esophageal	5.6	5.3
Kidney	13.5	12.2
Leukemia	10.1	11.5
Liver	4.2	4.4
Lung	72.5	70.3
Lymphoma	20.2	22.9
Melanoma	18.7	23.2
Oral/Pharyngeal	11.3	11.1
Ovarian	15.2	14.1
Pancreatic	10.8	10.8
Prostate	149.9	158.4
Stomach	5.8	5.7
Thyroid	6.8	7.4
Uterine	20.3	24.4

Source: Oregon State Cancer Registry Cancer in Oregon, 2006.

Adequacy of Local Public Health Services

III. Adequacy of Local Public Health Services

Linn County is fortunate to receive strong support from our Board of County Commissioners for public health services. During the recent budget cycle for 2012-2013 we were again flat funded. We were able to maintain the adequacy of local public health services and wrote several grants this past year including an adult immunization grant to focus on flu vaccine and DTaP for adults. Another important grant included the award for Healthy Communities funding. Linn County was one of seven counties to receive the implementation award for community health prevention activities.

All services for Linn County Public Health are available in both English and Spanish. Currently, our staff is 15% bilingual/bicultural. The impact of the state's new Early Learning Council and Coordinated Care Organizations (CCO) is unknown. We will continue to meet and discuss how public health can fit into the CCO model.

Linn County Public Health under the authority of the Linn County Commissioners acting as the Local Public Health Authority is fully compliant with the requirement for providing the five basic public health services as described in ORS 431.416 and all associated OARS.

The five basic services include:

A. Epidemiology and Control of Preventable Diseases and Disorders (Communicable Disease)

The communicable disease staff at Linn County continues to remain active and vigilant within the community. For 2012 the CD nurses investigated and managed 11 outbreaks and took 925 reports of communicable diseases²⁰. Nurses investigated and managed two case of active tuberculosis and managed 4 cases of latent TB. Staff was onsite at Albany Helping Hands shelter two days a week for TB screening and placed 579 TB tests in the past year. Linn County maintains timeliness of reporting to Oregon Public Health Division.

The communicable disease staff also remained active with community partners, working with Samaritan's Albany and Lebanon hospitals on infection control. CD nurses stayed actively involved with H1N1 activities through public education, vaccine distribution and direct service.

STI testing, treatment, and case follow-up are mandatory services offered by Linn County Public Health. Chlamydia is Oregon's and Linn County's most common reportable STI. the number of Chlamydia cases reported by all practitioners in Linn County increased once again. There were 360 reported Chlamydia cases this past year in 2012 compared to a 5 year average of 299.

²⁰ Linn County Public Health (2012) Communicable Disease Report
Linn County Public Health
Annual Plan 2013-2014

Immunizations

For the school year of 2011-2012, 1194 exclusion letters were mailed with 252 actual exclusions. The past school year 2010-2011, 1660 exclusion letters were generated with 232 exclusions. Part of the reason for the decreased number of letters this year was lower school enrollments and more students getting the required immunizations. In addition, immunization staff gave seasonal flu mist to 200 students in the Sweet Home school district.

There are many questions associated with why the overall vaccine rates have dropped recently in Linn County. Recent vaccine shortages as well as changes in the vaccine schedule have contributed to many children not being up to date in their vaccinations. Linn County is currently investigating the lower rates and looking for explanations. We have been fortunate to have an MPH student intern researching the declining immunizations rates for Linn County. One of the issues identified was the state no longer sending out reminder cards to parents. The absence of the 4th DTaP dose was the most common reason children were reported as not Up To Date (UTD) with the full series. There may also be some data issues that allow for children to be counted under Linn County's vaccination assessment, while in fact may have only received one vaccine with us and now are receiving them from another clinic. This can skew the results.

Immunizations are available at the clinics on a scheduled basis. We did give 2256 immunizations through our clinics and 346 employee seasonal flu shots this past year..

B. Parent and Child Health Services

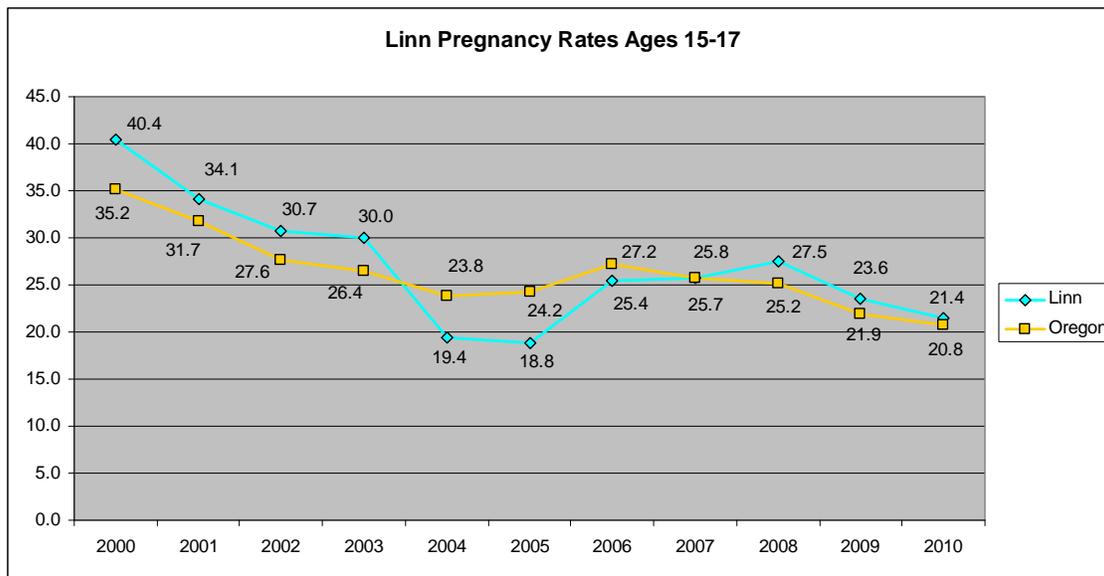
Linn County offers home visiting nursing services for parents and infants in the form of Maternity Case Management, Babies First and CaCoon.. Maternity Case Management referrals come from a list of social risk factors identified by a primary care provider or other care provider. Examples of such risk factors are young age, alcohol or substance abuse, mental illness, lower economic status, lower educational status among others. People identified with such risk factors are referred to Linn County for support and assistance to their specific needs. Maternity Case Management covers pregnant mothers and their newborns up to three months of age. Babies First operates similarly, but after the child is born and up to age five. Referrals are a mix of social and physical risk factors. Along with the social risk factors the parent may have, low birth weight, premature birth or other risks may flag a referral. The maternal care nurses at Linn County take referrals and make contact with parents and offer support services. CaCoon is also a referral service, but focuses primarily on physical condition of the child and less on social factors. Conditions such as heart disease, spina bifida, hearing loss, or autism spectrum disorders flag referral to CaCoon nursing staff. All programs are truly prevention in nature. Risk factors that are flagged are proven to be determinants of later child abuse, developmental delays or other hardships for the family. Early support, as well as matching families with vital services, works to help parents in difficult situations to raise a healthy child safely.

Linn County also provides support for first time parents in the form of the Healthy Start program. Healthy Start is a service that provides information on caring for a child as well as connects the parents with other community services. Children in Health Start are typically well babies and the referral is based on parental risk factors. Funding for our Healthy Start program is in jeopardy as we enter the last year of a federal Safe Schools grant. The unknown impact of the early learning council also threatens the existence of this important program in our county. We have not heard the funding level for the upcoming year. The program continues to see good outcomes including 98% of children establishing a primary care provider and 93% of children receiving up to date immunizations. 94% of parents reported reading to their child three times or more a week and 97% of parents reported positive parent-child interactions. 73% of parents reported having reduced parenting stress as a result of services²¹.

In the past year, Linn County saw 67 high need first birth families and engaged in intensive home visits through Healthy Start. 347 families were screened for community resource and service needs and 1029 visits were provided. 294 families received basic Healthy Start services. 261 children were engaged in Babies First and CaCoon services. 1085 home visits were provided by Linn County Public Health Nurses.

Family Planning:

Family planning services are offered to all ages of men and women.



Linn County offers full reproductive health and family planning services. Under the Federal Title X Family Planning Program we are able to see clients on a sliding scale based off ability to pay. Linn County also utilizes the Oregon Contraceptive Care (formally the family planning expansion project) or CCare extension of Medicaid. CCare is a program for people seeking contraceptive services and are below 185% of the federal poverty limit. Both the Albany and Lebanon offices have reproductive health

²¹ Linn County Public Health Healthy Start Program (2010) NPC Research Annual Status Report 2008-2009.

clinics. A nurse from the reproductive health clinic also travels to some county schools as well as the Community Services Consortium to give presentations on contraceptives and sexually transmitted diseases.

In 2010 Family Planning provided unduplicated service to 1945 clients and 417 unintended pregnancies were averted through contraceptive services including 131 teen pregnancies. These services combine to be a cost savings for \$3,127,500 for tax payers and \$928,500 for teen pregnancy alone. Unintended pregnancy prevention is based on method of birth control provided and factored by the state. Linn County does not provide abortions. As mentioned earlier, Linn County had a birth rate of 21.4 per 1000 for teens aged 15-17 in 2010 compared to 20.8 for Oregon.

Linn County provided Family Planning services to 27.1% of women in need of publicly supported family planning services in Linn County. 94.8% of Family Planning clients were below 150% of the federal poverty level.

27% of the Family Planning clients are teens. Resources provided to teens keep the pregnancy rate for 10-17 year olds in line with state averages. Pregnancy rate in 2009 for that age category was 8.8 per 1000, a drop from 10.6 2008.

Additionally Family Planning funded 12 vasectomies for low income men and helped 132 pregnant women access OHP and prenatal providers through Oregon Mothers Care.

Beyond contraceptive services Linn County Public Health is a contracted provider with the state for Breast and Cervical Cancer program (BCC). 67 women were screened by Linn County nurse practitioners. Additionally 88 more women were screen thanks to a gift from Soroptimist International of Albany.

C. Collection and Reporting of Health Statistics

In 2012, Linn County vital statistics registered a preliminary 981 death certificates and issued 4,468 certified copies of death certificates. The County also issued 236 certified copies of birth certificates. The County no longer registers births as they are registered directly with the state. All billing for vital Statistics is still done by hand as that phase of the computer system is still to come. The State computer system for vital stats is OVERS (Oregon Vital Events Registration System). The vital stats staff also compiles the communicable disease report monthly for our Board of Health account to county commissioners.

D. Health Information and Referral:

Linn County is active in maintaining strong partnerships with community resources in order to have current health related information. Through our recent community health improvement plan, we are working on referral pathways with our community partners. All of our information is available in English and Spanish. Over the past year the 211 information and Referral Service has been operational in Linn County. This service has

free information about more than 5000 health and community social services. Linn County Public Health is actively involved and listed in this resource.

Linn County Public Health provides health education information to several school districts with classroom presentations on reproductive health issues. We provide speakers on special interest topics, working with the local newspaper for coverage and making appropriate referrals as needed and or requested. Recently, we have been working with our mental health department to provide a streamlined system of referrals for our clients needing mental health services.

Other Services Important to Our Community:

Healthy Communities

In July 2012 Linn County Health Services received a 3 year Healthy Communities (HC) implementation grant from the Oregon Public Health Division. This grant provides the opportunity to implement areas of the Healthy Communities action plan that was produced in 2011 by the Healthy Communities Coalition. The HC program uses population-based initiatives that reduce the burden of chronic diseases most closely linked to tobacco use, physical inactivity and poor nutrition. Year ones funding of \$65,000 is being used in the following priority areas: 1) healthy Linn County worksites, 2) infrastructure for self-management programs, early detection of chronic diseases and tobacco cessation resources, and 3) community-wide health promotion and chronic disease prevention efforts. Creating communities where we all have access to healthy options is the Healthy Communities priority.

Oral Health

Linn County continues to have difficulty addressing the dental needs of adults as well as children. However, recently In-Reach clinic is helping establish a children's dental clinic at the Albany Boys and Girls Club. This will be a free standing clinic to serve children on an appointment basis.

Ryan White

Ryan White provides case management services to individuals with HIV or AIDS in Linn and Benton Counties. Clients are offered services and matched with community resources based on need. Linn County's case load is 76 clients and 2010 saw 4 new cases of HIV/AIDS. The number of new cases increases at the same time funding decreases.

WIC

WIC has been working hard under the direction of a new WIC supervisor to address strategies for decreased caseload. Recently, there was a slight trend upward for caseload attainment to 97% of caseload. The WIC program was lucky to obtain an additional downtown location for classes and breastfeeding peer counseling activities.

As part of the USDA's Women, Infant and Child program, Linn County administers WIC services to the county. WIC offers vouchers to purchase approved nutritious foods for mother and child and in certain cases medically prescribed formulas. Nutritional information and education is key to the program and clients must attend educational courses to maintain certification. Linn County serves over 6418 woman and children, issuing \$2.33 million in grocery vouchers and \$11,692 in farmer's market coupons. 44% of Linn County's pregnant women are on WIC. Thanks to nutrition and parenting classes associated with WIC, 86.9% of mothers in WIC start out breastfeeding.

The most significant change in Linn County WIC in 2010 was new funding to establish a Breastfeeding Peer Counseling program. Linn County was one of nine counties chosen for this funding. The program is due to get underway sometime in March 2011 and will involve recruiting pregnant participants who are interested in breastfeeding. There will be group sessions learning everything they need to know about breastfeeding. Recently, our WIC program was able to acquire an additional office and class room space in the Albany downtown area to hold the WIC peer breastfeeding classes as well as other WIC services.

Other Community Interactions

- Developed informational and promotional materials, including web-based media for distribution to the public.
- Received a grant to develop Flu immunization campaign targeted for adults for Flu and DTaP vaccine. This entailed working with private providers, hospitals, pharmacies, and businesses.
- Provide space for weekly Tuesday evening community Outreach clinic in East Linn and Thursday evening In-Reach clinic in Albany. In kind contribution
- Serve on numerous state committees.
- Grant writing to bring in additional program dollars- WE continue a strong partnership with the Soroptimist of Albany for woman's health issues –especially focusing on breast health.
- Linn County Public Health was a preceptor site for nursing students and public health interns from the following colleges and universities:
 - ✓ Oregon State University (OSU)
 - ✓ Western Oregon
 - ✓ Linn Benton Community College
 - ✓ Oregon Health Sciences University (OHSU)



III. ACTION PLANS

A. Epidemiology and Control of Preventable Diseases and Disorders

2013-2014

Linn County documented 670 confirmed cases and investigated 925 cases of communicable disease in 2012. All of the 670 confirmed cases were reported within the state specified timeline. Cases were reported, investigated and followed up in line with state investigative guidelines, and no change is needed. Linn County continues to experience an increase in rates of Chlamydia. We had 360 cases last year compared to a five year average of 299. Practitioners also reported 29 cases of Gonorrhea and 4 cases of Syphilis, compared to the five year averages of 28 and 1, respectively.

This past year we followed up on 11 outbreaks – of these 8 involved Norovirus. Linn County had 40 cases of Campylobacteriosis in 2012 compared to a five year average of 30 per year. In 2013, CD staff continues to follow up each case with a more extensive questionnaire at the request of state epidemiology to see if there is a commonality to the cases.

Linn County investigated and managed 2 active tuberculosis cases and 4 latent TB cases. The county continued to work with the local shelter to educate and test all the staff annually. We placed 579 TB tests last year. The primary TB nurse obtained advanced trainings on TB treatment and prevention through workshops with the state and national webinars.

Linn County had 2 new cases of HIV/AIDS. Our two part-time Ryan White nurses manage a case load of over 75 clients.

Time Period: 2012-2014				
GOAL: Provide effective communicable disease case management which includes responding to communicable disease reports 24/7, surveillance, investigation, education, and prevention activities to assure the health of the public.				
Objectives	Plan for Methods/ Activities/Practice	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. Maintain response to communicable disease calls 24/7	Test Linn County 24/7 response time and reporting two times a year.	Linn County staff will respond within 30 minutes of receipt of call to 24/7 number.	Met in 2012	Linn County Public Health staff continue to be available 24/7 to receive communicable disease reports.

Time Period: 2012-2014				
GOAL: Provide effective communicable disease case management which includes responding to communicable disease reports 24/7, surveillance, investigation, education, and prevention activities to assure the health of the public.				
B. Communicable Disease (CD) program registered nurses will continue to utilize ORPHEUS for disease surveillance, monitoring and reporting.	CD nurses will utilize ORPHEUS for disease reporting with all CD data being entered according to reporting requirements provided in the state investigative guidelines. ORPHEUS utilization will be expanded to generate local disease statistics to guide public health outreach.	>80% of cases will be investigated and reported within the timeline for the specific disease/condition.	Met in 2012	Linn County CD staff reported 100% of all cases within 1 day and completed investigation of 97.9% of cases within 10 days.
C. Continue to review/update policies annually and ensure a quality workforce through training.	Review policies annually and update as needed. Engage staff in training for new policies and procedures; encourage staff to utilize on-line training opportunities when possible and CD staff will attend OR-Epi if funding is available.	Policies and procedures will be up to date. Staff will stay current in CD practice.	Met in 2012.	All CD staff attended the 2012 OR-Epi conference.

Time Period: 2012-2014				
GOAL: Promote prevention of disease transmission in care home settings.				
Objectives	Plan for Methods/Activities/Practice	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. Assess educational needs of staff in Linn County Licensed Residential Long-Term Care Facilities.	Care facilities in Linn County were polled to determine the training needs of facilities.	All care facilities will be called and needs identified.	Met in 2012.	Webinar on why health care workers should receive influenza vaccinations was developed and presented within county and state-wide to care facilities. Letters were sent out in January to help mitigate Norovirus outbreaks. A presentation on MRSA was given to Adult Foster Home staff.

B. Provide infection control trainings to care homes in the county	Care homes will be contacted to arrange for training opportunities that include hand washing, standard precautions, and common disease transmission information.	All care facilities in Linn County will have an opportunity to receive training.	Met in 2012.	Talks were presented to Linn County care facility managers on infection control.
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Time Period: 2013-2014				
GOAL: Provide TB Prevention in homeless shelters in Linn County				
Objectives	Plan for Methods/Activities/Practice	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. Shelter TB plan will be reviewed and updated as needed annually	Annual training for review and updates will be provided for shelter staff by LCPH. LCPH will be available for additional on-going support and training as needed.	Shelter staff will participate in training as needed and policies will be up to date.	Met in 2012	Shelter TB plan reviewed in October, 2012. TB testing for all shelter residents discontinued due to very low incidence of TB in Linn County. TB testing and education to be continued for shelter staff on an annual basis.

B. Parent and Child Health Services

1. Babies First, Child Adolescent, Perinatal

Maternal Child Health Program Annual Plan For Linn County Public Health Fiscal Year 2013-14

Contact: Judy Treanor, RN MSN

A continuum of Public Health home visit programs serves Linn County pregnant women and families with young children.

1. Maternity Case Management (MCM)
2. Babies First (B-1st)
3. Care Coordination (CaCoon)
4. Healthy Start ~ Healthy Families of Linn County (HSLC)

Local collaborative projects in partnership with Linn County Public Health support families.

- Linn County Intimate Partner Violence and Pregnancy Coalition
- Linn County Early Childhood Team
- Linn County Infant Toddler Group

Program Accessibility

Linn County Maternal Child Health Programs are

- Available to serve all Linn County families
- Voluntary and free
- Capacity varies according to staffing level and program model
- Hours of service are Monday through Friday by appointments set up by parents and their Public Health Nurse or Healthy Start Family Support Worker.

Funding Sources

1. Maternity Case Management (MCM) County General funds, Linn County Commission on Children and Families, Medicaid fee for service, State General funds through the Oregon Health Authority for local Perinatal, Child and Adolescent services.
2. Mother's Care (OMC) State General funds through the Oregon Health Authority for local perinatal services
3. Babies First (B-1st) County General funds, Medicaid Targeted Case Management, State General funds through the Oregon Health Authority for local Babies First services
4. Care Coordination (CaCoon) County General funds, Medicaid Targeted Case Management, Funds through the Oregon Center for Children & Youth with Special Health Care Needs Child Development and Rehabilitation Center (CDRC) for local CaCoon services.
5. Healthy Start ~ Healthy Families of Linn County (HSLC) State General funds through the Oregon Commission on Children and Families, Medicaid Administrative funds, Safe Schools Healthy Students grant.

Linn County Perinatal Programs Serving Pregnant Mothers

Population Served	Service Goals and Focus	Referral Process	Intake Period	Staffing
<p>1. Maternity Case Management (MCM) serves Mothers and their Newborn during the perinatal period (prenatal through 8-weeks postpartum.</p> <p>50 pregnant women are served annually</p>	<p>1. Maternity Case Management (MCM) supports and assists pregnant women from early access to quality prenatal care, provide assistance a with the OHP application, referral to a medical provider and on-going service coordination.</p> <p>Services include home visits, advocacy, case management, education and the skills of a public health nurse monitoring and assessing the health and the needs of this family with potential for poor pregnancy and birth outcomes.</p> <p>MCM is offered to pregnant teens, women 40 + years of age, women who have had previous pregnancy problems – substance use, gestational diabetes and other chronic health problems that can cause a health problem for the pregnant woman and poor birth outcomes for the child. In the infant this includes low birth weight, prematurity, drug effects, genetic problems</p>	<p>1. MCM prenatal referrals are received from the community, Linn County OMC, community medical providers, hospital maternity care coordinators, public health programs, WIC and Healthy Start</p>	<p>1. MCM intake is typically during the first and second trimester</p>	<p>1. MCM is staffed by .30 FTE Public Health Nurse</p>

Linn County Perinatal Programs – Annual Plan and Evaluation for 2012-13

Problem	Issue	Goal	Activity	Evaluation
<p>Linn County's Comprehensive Assessment shows that almost 20 % of infants born were to mothers who use tobacco. As compared to Oregon statistics of 12 %.</p>	<p>Pregnant women who use tobacco during pregnancy are at risk for stillbirth, prematurity, low birth weight.</p> <p>Newborn Infants exposed to second smoke are at risk for SIDS, asthma and other respiratory problems.</p>	<p>Reduce the number of pregnant women who use tobacco by providing information, support and appropriate referrals at each encounter.</p>	<p>Staff training to learn basic tobacco intervention skills for the Maternal and Child Health practice.</p> <p>Training to include the 5 A's intervention model and the use of the Oregon Quit line.</p> <p>Update client handouts</p>	<p>Attendance at training in 2012. Result:10/25/2012</p> <p>50 Linn County health care providers and the MCH home visit team participated in the University of Arizona's Basic Tobacco Intervention Skills for Maternal and Child Health.</p>

Linn County Perinatal Programs – Annual Plan and Evaluation for 2013-14

1. 100 % of pregnant women served in the MCH program will be assessed for recent history of Tobacco use at intake. Results of this approach with pregnant women will be documented on the MCM ORCHIDS data sheets and in the women’s medical record on the Oregon Maternity Case Management 5A intervention form.
2. The percentage of women with recent history of Tobacco use will be documented and tracked as a percentage of women assessed in the MCH program.
3. 80 % of women with recent history of Tobacco use will be supported using the integrated 5 A’s intervention model at each encounter. Results of this approach with pregnant women will be documented on the MCM ORCHIDS data sheets and in the women’s medical record on the Oregon Maternity Case Management 5A intervention form.

Linn County Child Health Programs

Population Served	Service Goals and Focus	Referral Process	Intake Period	Staffing
<p>1. Babies First! (B-1st) serves medically and socially high risk infants and young children 0 to 5-years.</p> <p>200± children 0-5 years and their parents are served annually.</p>	<p>1. Babies First! (B-1st) a Public Health nurse engages a family with a high risk infant because of actual or potential risks for poor birth outcomes, attachment issues, problems with growth and development, and concerns about social and behavioral issues within the family situation. B-1st connects the infant to a medical home, assesses and monitors health, growth and developmental status, and provides service coordination. Voluntary in-home nurse visits are offered to families with children 0-5 years. Services include case management, advocacy, health, growth & developmental screening, health and parenting education, support and referral by a public health nurse.</p>	<p>1. B-1st referrals are risk based and made by medical providers, hospital nurses and social workers, the community, DHS child welfare and self-sufficiency staff, Public Health programs and WIC.</p>	<p>1. B-1st Newborn through age 5-years.</p>	<p>1. B-1st is staffed by 1.77 FTE Public Health Nurses</p>
<p>2. Care Coordination (CaCoon) serves children & youth 0-20 years with special health care needs. (SHCN)</p> <p>40± children with (SHCN)</p>	<p>2. Care Coordination (CaCoon) Public Health Nurses assist parents to be the case manager of their child’s special health care needs.</p>	<p>CaCoon Children or youth are referred by Hospitals, Medical Homes, Nurses Social Workers, Community Partners.</p>	<p>CaCoon intakes are done at birth through 20-years of age.</p>	<p>CaCoon is staffed by a .33 FTE Public Health Nurse.</p>

Linn County Child Health Programs continued

Population Served	Service Goals and Focus	Referral Process	Intake Period	Staffing
<p>3. Healthy Start (HSLC) serves first-time families prenatally or shortly after the birth of the baby. 50 to 60 % of families screened and offered basic service.</p> <p>Eligible families are offered intensive service for up to 3-years.</p>	<p>3. Healthy Start of Linn County (HSLC) offers a Welcome Baby service with information and regular home visits to eligible families having their first baby. The goal is to promote positive child interaction and relationship, readiness to learn, healthy thriving children, strong nurturing families and to prevent child abuse and neglect. Families at higher risk receive intensive home visit services with a trained Healthy Start Family Support Worker who provides parenting support, Parents As Teachers curriculum, developmental screening, and access to health care and community resources and services.</p>	<p>HSLC referrals come from the family's hospital Maternity Care Coordinator, Medical Home, Mother's Care provider, WIC, and community partners.</p>	<p>HSLC First-birth families are referred prenatally or shortly after the birth of their first baby.</p>	<p>HSLC is staffed by 2.4 FTE Healthy Start Family Support Worker.</p>

Linn County Child Health Programs – Annual Plan and Evaluation for 2012-13

Problem	Issue	Goal	Activity	Evaluation
<p>Linn County's Comprehensive Assessment shows that almost 20 % of infants born were to mothers who use tobacco. As compared to Oregon statistics of 12 %.</p>	<p>Pregnant women who use tobacco during pregnancy are at risk for stillbirth, prematurity, low birth weight.</p> <p>Infants and children exposed to second smoke are at risk for SIDS, asthma and other respiratory problems.</p>	<p>Reduce the number of children exposed to second hand smoke by providing information, support and appropriate referrals at each encounter.</p>	<p>Staff training to learn basic tobacco intervention skills for the Maternal and Child Health practice. Training to include the 5 A's intervention model and the use of the Oregon Quit line.</p> <p>Update client handouts</p>	<p>Attendance at training in 2012. Result. 10/25/2012 50 Linn County health care providers and the MCH home visit team participated in the University of Arizona's "Basic Tobacco Intervention Skills for Maternal and Child Health.</p>

Linn County Child Health Programs – Annual Plan and Evaluation for 2013-14

1. 100 % of children served in the MCH program will be assessed for recent history of exposure to 2nd Hand Smoke within their family system at intake. Results of this intervention with children will be documented on the Babies First/CaCoon ORCHIDS data sheets and in the child's medical record on a 5A intervention form.
2. The percentage of children with recent history of exposure to 2nd Hand Smoke in their family system will be documented and tracked as a percentage of children assessed in the MCH program.
3. 80 % of families whose children have recent history of exposure to 2nd Hand Smoke will be supported using the integrated 5 A's intervention model at each encounter. Results of this approach with the families of children will be documented on the Babies First/CaCoon ORCHIDS data sheets and in the child's medical record on the 5A intervention form.

2. Family Planning

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

July 1, 2012 to June 30, 2013
PROGRESS REPORT FOR 2013

Agency: Linn County Health Services

Contact: Norma O'Mara, R.N.

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.

Problem Statement	Objective(s)	Planned Activities	Evaluation
A significant amount of county general funds, Title X and CCare reimbursement supports our Family Planning program. We have identified that a significant number of clients do not pay for the services that they are obligated to pay. Our annual revenue for 2011 is down, and we need to look at ways to get the revenue for the service that staff has already provided for our clients.	To find ways to encourage our clients to pay their bills and avoid the repeated monthly statement that may not get paid and may later be written off due to non-payment of services.	<p>* Send Thank You notes to clients who are making progress on paying off their account balances.</p> <p>* Remind client at check in and check out of their outstanding balances. Offer debit as a form of payment.</p> <p>*Internal reminders in Raintree software to remind clerical staff to let clients know prior to their appointment that they have unpaid balances.</p>	<p>Set up a random list of clients to follow in their progress toward paying the amount that they owe. Also using Raintree review quarterly the client's ledger to see if the clients are paying their bills.</p> <p>Look at the number of clients and the amount owed for services currently, then see if there is an increase in clients paying their Bills each quarter.</p>
	To work within the Title X guidelines and county policies to develop new or better procedures for getting clients to pay	*Establish a billing committee to work on appropriate billing policies that are compliant with Title X and county	Review all current CPT codes to be sure that billing codes are correct for the various procedures.

	for their services on the day of service or to assist the client, if needed, to develop a payment plan. Look for areas and policies that may be impacting our ability to collect fees that are owed by our clients.	policies. Prioritizing of services for the low income as mandated by Title X.	
	Within the next 12 months increase the number of paying clients with reimbursable services, through either increased CCare enrollment, more OHP clients, insurance that reimburses the county, self-pay or sliding fee clients who get a service other than a "supply only."	<ul style="list-style-type: none"> * Educate the public on family planning services available through our two clinics. * Send a letter to all local physicians regarding the family planning services available and the options for payment. 	Track quarterly the number of new clients to our clinics after sending the letters to the physicians or to other agencies or local employers.
The cost of birth control supplies through the State identified supplier is often not the most cost effective option available for the county clinics. Saving resources will allow us to provide more preventive health care to our clients.	Locate a lower cost supplier of family planning medications and products in order to maintain or reduce our current budget. This will give the clinic an option to have funds available to maintain supplies for our current and future clients.	<ul style="list-style-type: none"> * Perform a cost comparison of 2-3 different suppliers and then establish a plan to purchase the identified lowest cost products as soon as possible in 2012. * With our savings we will purchase and distribute brochures to our clients on topics regarding preventable or perhaps reversible negative health conditions. 	<p>Monitor the cost of pharmaceuticals on a monthly basis in order to purchase birth control products and supplies from the most economical supplier.</p> <p>Monitor amount saved put toward educational materials on preventive health services for our clients.</p>

<p>We have been increasing yearly our distribution of ECs to our clients. There is some disparity in the percentage of those given to the under 20 and the 20 and over clients. Currently < 20 was given 38.9% of the time and the 20 & over was only 19.4% of the time. Current overall rate for both age groups is 24.2%</p>	<p>To increase the number of ECs distributed to 30% overall by increasing the number offered and given to the 20 and over age group.</p> <p>To increase our current rate for the < 20 level of 38.9% to 40% as a minimum.</p>	<p>*Continue to offer clients an “EC to go” and make sure that every new client is given one as a matter of routine unless the client strongly objects.</p>	<p>Monitor EC level with our annual statistics from the state.</p> <p>Discuss EC plan at monthly staff meetings at least quarterly as a reminder to give EC even if they are on a reliable method.</p> <p>Perform a simple survey to see if clients have an EC at home then offer them one if they do not have one available for their immediate use.</p>
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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.

Problem Statement	Objective(s)	Planned Activities	Evaluation
<p><i>A number of our Hispanic clients do not receive services in their home city. In 2009, 84.7% of our Hispanic clients receive services in our Albany clinic. There should be an increase in our Hispanic population utilizing Family Planning services in the Lebanon Clinic</i></p>	<p><i>To increase our Hispanic clientele in our Lebanon clinic for Family Planning services through having a Spanish interpreter working directly in the Family Planning clinic as the Medical Assistant.</i></p> <p>Anticipate some small decrease in the percentage of</p>	<p>*The Lebanon and Albany Hispanic WIC Certifiers will tell their Hispanic clients about the Family Planning services available in the Lebanon office.</p> <p>*A brief brochure in Spanish will be developed to inform</p>	<p>Utilizing Ahlers data, by July 2011, see a minimum of a 10% increase from 2009 in the number of Hispanics seen in our Lebanon office when compared to our Albany office.</p> <p>Survey Hispanic clients for a 2 month period of</p>

<p><i>as they become informed of our Hispanic interpreter in the Lebanon clinic.</i></p>	<p>Hispanic clients seen in the Albany clinic as clients move back to their home clinic in Lebanon for services.</p>	<p>the Hispanic clientele about our Lebanon clinic, which now includes interpreting services available within the Family Planning staff. This will be distributed through the Lebanon WIC clinic, and through the home visiting staff, and distributed at time of a positive pregnancy test through family planning and OMC.</p> <p>*There is a strong word of mouth referral system within the Hispanic community and we will distribute brochures and business cards to our existing clients. We will include our Lebanon clinic phone number, address along with our clinic hours on the cards and brochures.</p>	<p>time annually; ask how they heard of our services in Lebanon, if they are new clients to the clinic, or if they have returned to their home clinic in Lebanon from Albany.</p>
<p>As a Family Planning clinic, less than 1% of our clients are males. We need to increase the number of available services for our males in order to increase the percentage of our overall clients.</p>	<p>To increase the number of males who access our clinic for services. In the next 3 years we will increase the percent of male clients to at least 1.5%.</p>	<p>*Develop a policy that covers what male services are available through family planning by January 2012.</p> <p>*Research educational materials that will assist in establishing a male friendly clinic.</p>	<p>Monitor Ahlers data quarterly for numbers of participating males in the program.</p> <p>Increase male services above 1% by January 2012</p>

		* Educate staff regarding male services.	
Family Planning Services have been closed to our Sweet Home office and has impacted our rural and teen population's birth control options and services.	To offer a more convenient method for rural clients to receive their birth control products.	*Offer mail order birth control to clients, therefore saving appointment slots for new clients and for initial or annual examinations.	By April 1, 2012 complete the process and policy for mailing birth control products to our existing clients.
	To promote and increase the knowledge of the rural and general public regarding how to access our family planning services.	*Make our website more interactive and informative regarding how to enroll in CCare and what a family planning appointment would involve. *Advertise in the LBCC Commuter (student newspaper) which has a large circulation across Linn and Benton Counties. *Advertise our services in the Lebanon paper.	3 months and 6 months after updating our website: Survey our new clients to see how they heard about our services and ask if they accessed our website for information.
The uninsured often do not know where or how to access our services and need to be contacted utilizing different forms of media.	To increase the general public's knowledge about the services available to them through the family planning clinic in either Lebanon or Albany.	*Participate in different venues, and send out brochures or flyers, targeting larger local employers who might do not have benefits available for their employees but may be interested in distributing brochures to their employees.	Survey our new clients to see how they heard about our services. Survey will specifically ask what form of media the client accessed to find out about our clinic information and services.

		* Explore the possible opportunity to utilize social media and networking to contact potential clients.	
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Progress on Goals / Activities for FY 2012

(Currently in Progress)

Goal / Objective	Progress on Activities
<p>Goal 2: To find ways to encourage our clients to pay their bills.</p>	<ul style="list-style-type: none"> a. We have been sending Thank You notes to our clients when they are making regular payments or paying off their accounts. Some clients are randomly paying and many are making no attempt to pay their bill to us. Periodically reminders to clerical that we are still sending “thank you notes” to paying clients. b. We are placing pop ups in our appointment and billing system that alerts clerical staff at check-in that the client has an outstanding balance and they will explain the clients options for payment. (Cash, debit or credit.) c. Annually we write off any client account where there is 6 months without anything posted to their account. d. Looking at the top 50 accounts, the total amount due is approximately \$2400 less than one year ago. e. Our revenue hasn’t shown an increase as yet, but we have been without a Nurse Practitioner for 2 ½ months.
<p>To work within the Title X guidelines and county policies to develop new or better procedures for getting clients to pay for their services on the day of service or to assist the client, if needed, to develop a payment plan.</p>	<ul style="list-style-type: none"> a. We have a small group that has met just twice. Our goal is to develop a plan to assist our clients to make payments toward paying off their account. b. Blue Cross/Blue Shield is directly paying our clients for the services that “we” provide. We have made many attempts to contact Blue Cross/Blue Shield to get signed up as preferred providers so this will stop. We have lost considerable money because of their policies. c. We plan to connect with as many TPP as possible to be designated as a Primary Care Provider.
<p>Decrease the number of clients who were having difficulty getting their exam appointments in a timely manner.</p>	<ul style="list-style-type: none"> a. We were without a Nurse Practitioner for about 2 ½ months and our new NP required 4 months to become fully functioning and able to carry a full load of clients. Her function primarily is annual examinations and STD exams.

	<p>b. Clients are keeping up with their annual requirements, it is necessary at times to explain the rules about being a patient, under the 340B definition. We have monitored that carefully as those clients who are coming for birth control only don't meet the Federal 340B definition of a "patient".</p>
<p>Within the next 6 months increase the number of paying clients with reimbursable services, through either increased CCare enrollment, more OHP clients, insurance that reimburses the county for services or by those self-pay or sliding fee clients who get a service other than a "supply only."</p>	<p>a. Reproductive Health staff has been going to the Lebanon and Albany High Schools to discuss birth control and STDs. RH staff has given many presentations to health classes last year at the local high schools. Plans for 2013 include more classes.</p> <p>b. Second year to outreach with LBCC for increased awareness of our services by attending the new student orientation fair in August 2012. We also placed an ad in the first 2012 school year edition of the college newspaper.</p> <p>c. In 2010 we enrolled 355 new clients; in 2011 that number was 363 and in the first 3 quarters of 2012 we have enrolled 247 new clients.</p> <p>d. We are seeing an increase in our teen population specifically. In 2010 we enrolled 133 new teens; 2011 was 122 new teens; and 2012 (3 quarters of data) 86 new teens.</p> <p>e. We have not made contact with the LBCC Leadership group this year but for the second year we have taken LBCC nursing students into the clinic for their practicum. We have three schools of nursing that participate with our clinic for their nursing students needed practicum.</p> <p>f. A Mail order birth control policy is written but not yet approved. Plan for implementation by April 2013.</p> <p>g. We still need a letter to the physicians regarding our services and more targeted advertising.</p> <p>h. Our ability to improve our website for the county is nearly an impossible task, due to competing needs for IT staff and the usual shortage of staff. The pressure from the rapid implementation plans of the ACA and CCO's has required a shift in many previous priorities in order to maintain our viability.</p>
<p>We are planning to lower the cost of our medication and clinic supplies by locating the most economical supplier available.</p>	<p>a. After looking at the monthly budget for 2011 our supplies had increased significantly and warranted a look at a different provider for those supplies. We have been successful and the service and price both are superior. We started our new supplier 9/1/12 so we have only a small sample to compare against our previous supply charges. It is obvious that we are saving. Our new supplier has monthly specials and we have upgraded</p>

	<p>some of our supplies and equipment due to these specials. We also assist WIC and Mental Health with purchasing supplies to save on their budgets as well.</p> <p>b. We need to carefully evaluate the brochures we carry and make informed decisions about the best ones to purchase for our client's needs. We have not completed this at this time.</p>
<p>To increase the number of ECs distributed to 30% overall by increasing the number offered.</p> <p>To increase our current rate of "EC to go" for the <20 year olds for future need. Goal is to improve the current level of 38.9 to 40% as a minimum.</p>	<p>a. Our 2011 data show an increase of EC distribution to our clients to 35.3%. We are monitoring this process through our QI committee. We did a survey to determine if staff is asking clients if they want an "EC to go". We need to repeat our survey, as staff knew we were doing this survey and that may have skewed the data regarding the actual % offered EC at their visit.</p> <p>b. We discovered through our QI process that the < 20 year olds were receiving 74.8% of the total ECs given for their future need. But it was the >20 year olds who were coming in for EC immediate need. This data will be provided to staff at the December staff meeting and a refocus on increasing our numbers for both the <20 and >20 age group.</p> <p>a. 2012 data show for the <20 age group 40.7% were given EC for future need. More improvement is needed.</p> <p>b. The teen pregnancy rate for Linn County in 2011 was 8.8 and for 2012 it is 5.7. Our presence in area schools is a significant factor as we give important prevention information and how to access our services.</p>
<p>Goal 4: A number of our Hispanic clients do not receive services in their home city. 84.7% of our Hispanic clients receive services in our Albany clinic. There should be an increase in our Hispanic population utilizing Family Planning services in the Lebanon Clinic as they become informed of our Spanish interpreter in the Lebanon clinic.</p>	<p>a. Our Hispanic WIC certifier has continued to educate many of her Spanish WIC clients about Reproductive Health services available in the Lebanon clinic.</p> <p>b. We have seen a slight reduction in the overall number of Hispanic clients coming to our clinics.</p> <p>c. Lebanon has added new Hispanic clients in the following years - 7 (2010), 4 (2011) and estimated for (2012) is 7 new clients. Albany has larger numbers of Hispanic clients being added to their clinic.</p> <p>d. For 2010 77% of the Hispanic clients received services in our Albany clinic, in 2011 it was 84.7%, and in 2012 (3 quarters of data) the percentage is 79%.</p>

<p>Anticipate a small decrease in Hispanic clients as they move back to their home clinic in Lebanon for services.</p>	<ul style="list-style-type: none"> a. Yet to be developed is a brochure in Spanish which specifically focuses on the services available to the clients at the Lebanon clinic. b. Still need to get business cards for the Lebanon clinic made in Spanish. c. Need to complete a survey for both clinics in Spanish. Planned for Spring 2013.
<p>As a Reproductive Health clinic, less than 1% of our clients are males. We need to increase the number of available services for our males in order to increase the percentage of our overall clients.</p> <p>Develop a policy that covers male services.</p>	<ul style="list-style-type: none"> a. The statistics used by the state and reported to us in Reproductive Health do not include any of our STD client numbers. Most of the numbers reported through our Ahlers data represents only our vasectomy clients. b. In 2011 the percentage of male clients was at .9% of all RH clients. The statistics for 2012 show males to be at 1.1% of the clients. c. Need to include the number of male STD clients in the total number of males served by the entire program. d. In order to increase our RH numbers we have initiated specific male services. This includes counseling and male examinations. In order to see an increase we will need to spend more of our time and efforts to advertise these services to our male population. <ul style="list-style-type: none"> a. Policy is completed for male services but still needed is a male exam form, which could be used for male exams and male STD appointments. b. Key opportunities would be when males call for STD appointments. Many could be converted to CCare paid male contraceptive counseling appointments. This would also cover our routine testing for CT/GC on all of our first time clients.
<p>The reduction in Reproductive Health's direct services to the rural area has had an impact on our teen population's birth control options and services.</p>	<ul style="list-style-type: none"> a. In an effort to provide services to more clients we are initiating a mail order service for delivering birth control supplies to our regular clients. This has been delayed due to lack of staff to medically monitor the program. An RN must monitor this program because of Oregon State pharmacy rules and best practice. This program is now set to start no later than April 2013. Existing staff will be overseeing this service. b. The policy is written and ready for approval by our Medical Director. This should reduce many of the access issues that teens and adults may have in picking up their birth control supplies.

<p>To promote and increase the knowledge of the rural and general public regarding how to access our Reproductive Health services.</p>	<ul style="list-style-type: none"> a. Updating our website for Reproductive Health and STD's is definitely needed but not on the list of current IT projects. With the rapid roll out of the ACA and the CCO's in Oregon. Additionally deadlines for establishing the new ICD10 billing codes and initiation of EHRs for the clinics, the improved website may not be done for some time. b. Through our website several emails have been generated with potential clients, where they post questions for the RH Supervisor. Usually the topics are most often on how to access our services, but some may be more specific in their need for information. c. Looking into the use of other forms of social media to interact specifically with the youth, potentially starting a Facebook for Reproductive Health. d. We have placed an ad in the local Community Colleges newspaper at the beginning of the school year. Need to establish a plan for regular advertising to the students. e. Need to see what the cost is to advertise in the Sweet Home and Lebanon newspapers and put that into the budget. f. No current survey has been done to evaluate our communication needs. g. We have participated in several local health fairs, homeless fairs, and the new student orientation at the local Community College. We use student nurses from three different Schools of Nursing to present education, they assist by making posters, and also have assisted in writing valuable client education for our clients. h. Perhaps in the future we will be able to update our RH brochures.
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**OFFICE OF FAMILY HEALTH
ADOLESCENT HEALTH ANNUAL PLAN
FY 2013**

Agency: Linn County Health Services

Contact: Norma O'Mara, R.N.

Goal # 1: Through our Health Services Clinics we will focus on health goals and services appropriate for adolescents by providing accurate information, giving quality and respectful care which is age appropriate and available to all youth.

Problem Statement	Objective(s)	Planned Activities	Evaluation
<p>Sexual health, accurate sexual education and preventing pregnancies and sexually transmitted diseases are vital for supporting healthy teens within our community.</p> <p>As a clinic providing services to teens, as well as adults, we will increase our focus on how and what we present to the teen population. We will need to focus our efforts on providing age appropriate and accurate information with a goal to maximize the time we have available in clinic.</p>	<p>“Knowledge is Power” is a strategy to reduce our teen pregnancy rate. In 2010 the Linn County teen pregnancy rate was 10.2%. Increase knowledge of services available for birth control with a primary focus on teens.</p>	<p>Educate teens in how the reproductive system works as most young women do not know the basics of how conception occurs. This will occur by having the appropriate posters, brochures and anatomical model available in our exam and counseling rooms. Staff will engage the teens in what their knowledge level is in regard to their own body function.</p> <p>Advertise services to the teen community through places where teens normally meet.</p> <p>The client will return within three months to be sure that they are using their birth control method correctly and will evaluate clients for barriers to their taking their birth control.</p> <p>Work to increase the number of teens served through other family planning activities.</p>	<p>Include in a specific teen survey after 1 year from implementation to determine if teens are knowledgeable about their reproduction. Can be included with other questions focused on teen risks in Goal #2.</p> <p>Evaluate annually if more teens are accessing our website and make contact for more information.</p> <p>Annually determine if we are increasing our “new” teen client numbers and reassess activities as needed.</p>

<p>Our clinic serves clients age 12– 60 for services but we need to provide high quality with a focused service for our teen population.</p>	<p>To increase the quality and service to our teens that presents a message that, as teens, they are important to us and our clinic.</p>	<p>Provide Mail Order birth control for existing clients.</p> <p>Give talks at schools on how to access our services and how teens qualify for the free birth control program.</p> <p>Use young interns and nursing students to provide staff closer in age to the teens, and to have them assist us to make our clinic more teen friendly.</p>	<p>By April 2012 provide Mail Order service for birth control.</p>
<p>Teens communicate utilizing different forms of media. To communicate effectively with the teens, we as a clinic need to utilize the form of media that they find to be most effective.</p>	<p>To improve our Website with a greater focus on teen needs.</p>	<p>Add a virtual tour of a clinic, ours if at all possible.</p> <p>Improve links on our Website focused on birth control. Increased information specific for teens.</p> <p>Look into option for social media to encourage teens to come to clinic.</p> <p>Communicate via text messaging for appointments and other communications when approved by the teen.</p>	<p>Start work on changing the website and providing links to the state website with emphasis on teen information within 2012.</p> <p>During 2012 determine the feasibility of engaging in some form of social media for our clinic such as Facebook.</p>
<p>Teens are concerned about their personal confidentiality in the sexual health services that are provided through our clinics.</p>	<p>To provide the client with the reliability of knowing that their care with us remains confidential.</p>	<p>Make available the written information, on site, about the legal rights of teens to make their own decisions regarding birth control and STD testing and treatments</p> <p>Provide daily walk-in EC service for teens.</p>	<p>Have available by March 2012 “Minor Rights” (booklet by OHA) available in the rooms for teens.</p>

Goal # 2: Known risks to teens need to be highlighted and a plan made to address those risks through and in our clinic practice. Our goal is to reduce those that we have the ability to personally impact. Teen identified risks include; teen pregnancy, sexually transmitted diseases, suicide, alcohol and drug use, intimate partner violence and sexual coercion. As a family planning and STD clinic we can impact most of the above identified risks to some degree.

Problem Statement	Objective(s)	Planned Activities	Evaluation
The state's highest incidences of STDs are in the age group 17 – 25. Linn County is no exception; in 2011 we had 67 documented cases of Chlamydia or Gonorrhea in the 20 and under age group in our Lebanon and Albany clinics.	To reduce STI's to less than the CY 2011 figures as listed in those 20 and under in our clinics. There may be an increase initially in the figures for 2012 due to the increased testing planned as a mechanism to the overall reduction in STDs over the next 3 years in our teen population.	Testing all those who enter the clinic for services at their first visit for STIs. Start 1/2/12	Annually, check our internal data to see if the numbers of positive CT/GC tests are decreasing each year in the less than 20 age group.
Teen suicide and attempts in Linn County is at approximately the same level as the state average. But if one child dies that is one too many.	Educate our clients – both teens and parents regarding the dangers of the Choking Game.	Post pamphlets and posters regarding the Choking Game in the clinic. Include in the pamphlet and on our website links to the CDC Podcast on the choking game and additional "YouTube" video links that show or explain the risks of the Choking Game. Provide an environment where teens feel comfortable and supported in order to share their concerns.	Monitor if the pamphlets are being taken and if questions are being asked about teen concerns around suicide. Regularly inquire teens if they have heard of or participated in the choking game themselves and if they understand the risk.

Teen Pregnancy addressed above in Goal 1.			
Approximately 1 in 4 women experience Intimate Partner violence. An increasing number of teens do not have healthy relationships, including IPV, date rape or sexual coercion.	To decrease the number of teens experiencing sexual violence, abuse or coercion.	During clinic visits the staff will be routinely asking questions about IPV and discussing possible sexual coercion by partners. DOJ and Public Health have a grant to out station a CARDVA advocate at Public Health to be available to address these issues with our clients.	Monitor if the CARDVA or sexual abuse brochures are being taken. Monitor if we are making referrals to CARDVA in the next year and utilizing our onsite CARDVA advocate.

Part 1. Assessment of activity areas you are involved in regardless of whether you have a well-defined plan or program in place

1) School-Based Health Centers

- a) There are no school based health centers in Linn County. There was a previous attempt to establish a school based health center, but the community interest was not there at that time. We will continue to keep the lines of communication open with the superintendents and consider a survey in the future to identify local areas of interest.
- b) Participate within the schools as much as possible.

2) Coordinated School Health (Healthy Kids Learn Better) Schools

- a) No involvement

3) Teen Pregnancy Prevention & Contraceptive Access

- a) We make presentations regularly at 2 of the local high schools in Albany and Lebanon on the subject of Birth Control and STDs. The school health teachers regularly request presentations several times per year. On average family planning staff goes to the school 6-8 times per year for the presentations. We are also presenting birth control information at the local juvenile detention center at Oak Creek. We feel this is important and will maintain a focus and presence in this area. We do not have a health educator dedicated to family planning, so we rely on our existing staff. We have also been giving presentations to the local alternative education program in Albany.
- b) Home visiting nurses participate in the “Teen Task Force” in East Linn County; staff is an integral part of the Lebanon High School's class for pregnant and parenting Teens. In the Albany school district they participate

and collaborate with the FACT program, who case manages students who are pregnant or parenting.

- c) Members of the Family Planning staff meet monthly with the local hospital Maternity Care Coordinators to work as a community team regarding support and referrals for pregnant teens and adults as well.
- d) Look into the use of other forms of social media to interact with youth.
- e) Update website for Family Planning and STD's.

4) Work with High School health teachers to insure the teens are referred for appropriate services as needed.

- a) Working with teachers and school nurses to present current up to date information on birth control and STIs.
- b) Participates regularly with the Teen Pregnancy Task Force in East Linn.

5) Continue oversight and coordination of My Future My Choice contract and services in Linn County.

- a) We still have a contract with the state and one of the Mill City schools was interested but at this time we have no signed or official contract with them.

6) Youth Suicide Prevention

- a) We track youth suicide statistics for Linn County and present them as part of our monthly report to our County Commissioners. From January 2009 through December of 2009 there were no youth suicides in Linn County.
- b) See Goal 2.

7) Tobacco Use Prevention & Cessation

- a) Our Tobacco Coordinator provides activities which specially focus around schools and adolescents includes: providing information regarding the Quit Line to school partners for inclusion in their back to school newsletters, assist school partners to establish policies around smoking.
- b) The rate for 11th graders smoking has increased in the last 6 years and has gone from 14% to 23% in 2011. State level currently is at 11%. We will be attempting to identify what has caused this increase and make future plans to address them.

8) Alcohol & Other Drug Use Prevention

- a) Talk with teen clients in our family planning and STD clinics and give them information about drug use. We provide education at visits and during school presentations.
- b) Discuss the role of alcohol and drug use in the practice of "unsafe sex". Have handouts on drugs and alcohol use, placed for easy client access available in the each client room.
- c) Presentations at the local schools will include information regarding the effect that drugs and alcohol have on one's ability to remember to take their birth control, or having sex with an unknown partner or not maintaining one's personal goal of abstinence.

Part 2. Assessment of Current Activities Related to Adolescent Health

Individual client services are those that are generally delivered one-to-one or in groups.

Community activities are those efforts that bring community members together to address a topic, or that provide health promotion or education to the community in general.

Health delivery system activities are those that result in linking individuals or communities to needed health care or other services, through coordination, collaboration, or communication.

TOPIC OR HEALTH RISK AREA Current Activities/Involvement	Individual Services	Community Activities	Health Systems Delivery
Access to care	X	X	X
Comprehensive screening (GAPS/Bright Futures)			
Parent/family involvement	X		X
Primary care services		X	X
Mental health services		X	X
Youth suicide prevention	Refer		X
Depression screening	X		X
Teen pregnancy prevention	X	X	X
Contraceptive access	X	X	X
Condom distribution	X		
ECP promotion	X	X	

TOPIC OR HEALTH RISK AREA Current Activities/Involvement	Individual Services	Community Activities	Health Systems Delivery
STD/HIV prevention	X	X	X
STD/HIV counseling	X	X	X
Tobacco prevention	X	X	X
Tobacco cessation	X	X	X
Alcohol & Other Drug (AOD) Use Prevention	X		X
AOD Assessment/screening			
Nutrition Promotion	X limited	X	X
Physical Activity Promotion			
Motor vehicle Safety			
Seat belt use			
DUII			
Street Racing			
Violence Prevention			
Harassment/Bullying			
Physical fighting			
Weapon carrying			

TOPIC OR HEALTH RISK AREA Current Activities/Involvement	No plans to expand	Would like to expand	Would like more info or assistance
Access to care		X	X
School-Based Health Centers			X
Comprehensive screening (GAPS/Bright Futures)			X
Coordinated School Health (Healthy Kids Learn Better)			X
Parent/family involvement		X	X
Primary care services	X		
Mental health services			
Youth suicide prevention			X
Depression screening	X		
Teen pregnancy prevention		X	X
Contraceptive access		X	
Condom distribution		X	X
ECP promotion		X	X
STD/HIV prevention		X	X
STD/HIV counseling		X	X
STD/HIV treatment		X	X
Tobacco prevention		X	
Tobacco cessation			

Alcohol & Other Drug (AOD) Use Prevention			
AOD Assessment/screening			

Part 3. Assessment of Future Interests Related to Adolescent Health For the topic areas or health risks:

TOPIC OR HEALTH RISK AREA Current Activities/Involvement	No plans to expand	Would like to expand	Would like more info or assistance
Nutrition Promotion		X	X
Physical Activity Promotion		X	X
Motor Vehicle Safety			
Seat belt use			
DUII			
Street racing			
Violence Prevention			
Harassment/Bullying		X	X
Physical fighting			
Weapon carrying			

3. Immunizations

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

Linn County Health Department

LHD staff completing this checklist: Jane Fleischbein

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:**

Activity 1: Reactivated burp cloth project for newborns at Samaritan Lebanon Community Hospital which gives new moms a burp cloth, immunization schedule and information on where to obtain immunizations.

Activity 2: Presentations given to WIC prenatal clients on importance of Dtap and other immunizations.

(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 User's 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

Q. 44 1.(DTaP rate) Linn County was unaware the state was no longer sending reminder postcards to clients needing 4th DTaP. We have initiated steps to send out reminders to clients needing 4th DTaP.
--

Q. 44 5. (ALERT IIS data entry timeliness) Clerical help has been added to improve timeliness of data entry; April - October 2011 rates have been improved to > 80%.
--

4. WIC

FY 2013 - 2014 Oregon WIC Nutrition Education Plan Form

County/Agency: Linn County
Person Completing
Form: Cindy Cole, RD, LD
Date: 11/30/2012
Phone Number: 541-967-3888, Ext. 2583
Email Address: cycole@co.linn.or.us

Return this form electronically (attached to email) to:
sara.e.sloan@state.or.us by December 1, 2012
Sara Sloan, 971-673-0043

Goal : Oregon WIC staff will continue to provide quality participant centered services as the state transitions to eWIC.

Objective 1: During planning period, WIC agencies will assure participants are offered and receive the appropriate nutrition education contacts with issuing eWIC benefits.

Activity 1: By December 1, 2013, each agency will develop and implement a procedure for offering and documenting nutrition education contacts for each participant based on category and risk level while issuing benefits in an eWIC environment.

Note: Information and guidance will be provided by the state office as local agencies prepare for the transition to eWIC.

Implementation Plan and Timeline:

The Linn County WIC program will continue to offer nutrition education contacts in the form of individual appointments and group sessions for each participant based on category and risk level as appropriate. These will be scheduled upon initial certification of a participant and at following recertification appointments. Each contact will be documented in the nutrition education screen in Twist. Pending guidance from the state office regarding changes in Twist, this will continue to be the standard service and documentation plan.

Linn County will be one of the pilot eWIC sites. We expect to begin training in August and begin implementation in September.

Objective 2: During planning period, Oregon WIC Staff will increase their knowledge in the areas of breastfeeding, baby behavior and the interpretation of infant cues, in order to assist new mothers with infant feeding and breastfeeding support.

Activity 1: By March 31, 2014, all WIC certifiers will complete the new Baby Behavior eLearning online course.

Note: Information about accessing the Baby Behavior eLearning Course will be shared once it becomes available on the DHS Learning Center.

Implementation Plan and Timeline:

In-service training regarding Baby Behavior eLearning Course will take place at the WIC staff January staff meeting.

A log sheet will document those in attendance.

Activity 2: By March 31, 2014, all new WIC Staff will complete the Breastfeeding Level 1 eLearning Course.

Note: Information about accessing the Breastfeeding Level 1 eLearning Course will be shared once it becomes available on the DHS Learning Center.

Implementation Plan and Timeline:

Coordinator will assure that staff hired in FY 2013-2014 will complete the Breastfeeding Level 1 eLearning course.

Objective 3: During planning period, each agency will assure staff continue to receive appropriate training to provide quality nutrition and breastfeeding education.

Activity 1: Identify your agency training supervisor(s) and projected staff in-services dates and topics for FY 2013-2014. Complete and return Attachment A by December 1, 2012.

Implementation Plan and Timeline:

See Attachment A

EVALUATION OF WIC NUTRITION EDUCATION PLAN

FY 2012-2013

WIC Agency: Linn County

Person Completing Form: Cindy Cole, RD, LD

Date: 11/30/2012 Phone: 541-967-3888, Ext. 2583

Return this form, attached to an email to: sara.e.sloan@state.or.us by December 1, 2013

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

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

Year 3 Objective: During planning period, staff will continue to incorporate participant centered education skills and strategies into group settings.

Activity 1: By March 31, 2013, WIC Training Supervisors will complete the online Group Education Course.

Evaluation: Please address the following questions.

- Did your agency's Training Supervisor(s) complete the online Group Education Course?

We have been advised by Vernita to wait for the updated version of this module. It will be added to next year's nutrition education plan. (See October 2013 on Attachment A).

- Was the completion date entered into TWIST?
Not applicable (see above).

Activity 2: By June 30, 2013, WIC staff who lead group sessions and participated in the regional Participant Centered Groups trainings in 2012-2012 will pass the posttest of the online Group Education Course.

Evaluation: Please address the following question.

- Did staff who lead group sessions and participated in the regional Participant Centered Groups trainings pass the posttest of the online Group Education Course?

This is on our schedule to complete by 6/30/13.

- Were completion dates entered into TWIST?
Will complete by 6/30/12.

Activity 3: By March 31, 2013, each agency will evaluate at least four nutrition education group sessions and at least one local agency staff in-service using the state provided group session evaluation tool.

The tool is located on the State WIC website:

<https://public.health.oregon.gov/HealthyPeopleFamilies/wic/Documents/orwl/pcg-ho-evaluating-session-guides.pdf>

Evaluation: Please address the following questions.

- Did your agency evaluate at least four nutrition education group sessions and at least one local agency staff in-service?

This is on our schedule to complete by 3/31/13.

- What changes, if any, were made to the group sessions or staff in-service after completing the evaluations?

To be determined.

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

Year 3 Objective: During planning period, each agency will continue to incorporate participant centered skills and strategies into their group settings to enhance breastfeeding education, promotion and support.

Activity1: By March 31, 2013, each agency will evaluate at least one prenatal breastfeeding class using the state provided group session evaluation tool. The tool is located on the State WIC website:

<https://public.health.oregon.gov/HealthyPeopleFamilies/wic/Documents/orwl/pcg-ho-evaluating-session-guides.pdf>

Evaluation: Please address the following question in your response:

- Did your agency evaluate at least one prenatal breastfeeding class?
Yes, two classes were evaluated.
- What changes, if any, were made to the group session after completing the evaluation?
The evaluation reinforced the value of participant centered education and that it is working in this setting. We will keep making PCE teaching style a priority.

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

Year 3 Objective: During planning period, each agency will continue to build partnerships with identified referral organizations in their community.

Activity 1: By September 30, 2012, each agency will review their list of referrals in TWIST and identify at least one unfamiliar organization in order to learn more about the service they provide to WIC participants. By March 31, 2013, each agency will then invite a representative from that organization to give a short presentation about the services they provide at an "All Staff" meeting.

Evaluation: Please address the following questions.

- Which community partner organization(s) did your agency identify to learn more about the services they provide?

Family Tree Relief Nursery

- Was a representative from that organization invited to give a short presentation to WIC staff about their services?

Yes, the Director of Family Tree Relief Nursery attended our staff meeting on 9/5/12. She explained the purpose of her organization and how WIC staff can refer to her services.

- What went well and what would you do differently?

The meeting went very well. We plan to have one of her staff members be present at expos in Albany, Lebanon, and Sweet Home.

Activity 2: By September 30, 2012, each agency will review their list of breastfeeding referrals in TWIST and identify at least one organization that they would like to meet with to strengthen their referrals. By March 31, 2013, each agency will invite a representative from that organization to discuss how they can partner together to enhance breastfeeding support in their community.

Evaluation: Please address the following questions.

- Which community partner organization(s) did your agency identify to strengthen breastfeeding referrals?

MidValley Children's Clinic Lactation Consultants

- Was a representative from that organization invited to discuss how they can partner with WIC to enhance breastfeeding support in your community?

Yes, they attended our meeting on 11/29/12.

- What went well and what would you do differently?

We saw great value in meeting face to face. It was obvious that there were gaps in understanding of each other's services. We discussed the WIC peer counseling program, WIC pump services, WIC certification process, Medical Documentation Forms, Mid Valley Children's Clinic and Samaritan Albany General Hospital lactation services, and the newly formed Linn-Benton Breastfeeding Coalition. Unfortunately some of our staff was absent from this meeting due to illness. We plan to attempt to meet 2-4 times per year from now on.

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

Year 3 Objective: During planning period, each agency will continue to increase staff understanding of the factors influencing health outcomes.

Activity 1: By March 31, 2013, each agency will develop and implement a plan to assure staff are communicating health outcomes to participants during certification visits.

Evaluation: Please address the following questions.

- Was a plan developed and implemented to assure staff are communicating health outcomes to participants during certification visits? [x] Yes [] No. If no, please explain why not.

A self-evaluation form was developed to be completed at 5 certifications answering the following 3 questions:

- 1) What did you state is the reason the participant is enrolled in WIC?
- 2) How long did you tell the participant that the certification period will last?
- 3) What health outcome did you tell the participant that WIC is hoping to achieve by their being on the program?

Results of self-evaluation will be reported to WIC coordinator and summarized at group staff meeting.

This will be accomplished by 3/31/13.

- What went well and what would you do differently?

To be determined.

Activity 2: Identify your agency training supervisor(s) and projected staff in-service dates and topics for FY 2012-2013.

Evaluation: Please use the table below to address the following.

- Name of Training Supervisor.
- In-service topic and date.
- Method of training.
- Core Competencies addressed (CPA Competency Model Policy 660, Appendix A) and/or Outcome of In-service.

FY 2011-2012 WIC Staff In-services

Name of Training Supervisor: Leah Brunson, (Cindy Cole)

In-Service Topic and Date	Method of Training	Core Competencies Addressed/ Outcome of In-Service
Postpartum Nutrition Module July and August 2012	DHS Learning Center Postpartum nutrition module attempted in staff meeting, but technical problems forced it to be completed by staff on their own. Completed by all by the end of August 2012.	Module addresses core competencies in delivery of postpartum nutrition education to WIC clients. Outcome will be enhanced delivery of postpartum services.
Best Practices: Managing Early Breastfeeding Challenges August 17, 2012	One day presentation by Molly Pessl, BSN, IBCLC. Conference setting also allowed interaction between WIC staff and our community partners who provide breastfeeding support.	Presentation addressed issues around barriers to breastfeeding success in the hospital and home setting as well as common sense approaches to help with early breast feeding challenges. Outcome: Evidence based breastfeeding information for WIC staff and our local healthcare community as well as strengthening of partnerships.
In service by Family Tree Relief Nursery Director, Rene Smith September 5, 2012.	Director attended Sept staff meeting to explain services provided by Family Tree Relief Nursery. These include support service for parents in the form of therapeutic classroom, home visits and parent education.	Goal was to share program services with WIC staff and remind Director of WIC services as well. Outcome included plans for Family Tree Relief Nursery staff to be present at future clinic expos.
Poverty Competency September 27, 2012	Half day workshop presented by Donna Beagle, Ed.D. as part of an "all public health" staff training day.	Presentation included: -Poverty realities in America -Types of poverty -Strategies to break poverty barriers -Communication strategies to use with oral culture learners Outcomes included increased awareness of the "Culture of Poverty" and how the delivery of WIC services can impact an individual in poverty.

<p>Strengthening Referrals in Twist September 27, 2012</p>	<p>PCE centered staff in-service at September staff meeting.</p>	<p>Competencies included: -Ability to identify meaningful referrals in Twist based on need -Correct documentation of referrals in Twist -Ability to describe situations when a staff member is required to make referrals. Outcome expected: improved health outcomes of WIC participants by enhancing the quality of referrals made by WIC staff.</p>
<p>MidValley Children's Clinic Lactation Consultants November 29, 2012</p>	<p>Two lactation consultants who work for a large pediatric practice in Albany attended our monthly staff meeting.</p>	<p>Goal was to reinforce collaborative relationship between WIC and local pediatric office. Outcome: improved understanding of each other's services and plans to meet again to enhance services to shared WIC clients.</p>
<p>In services planned for January 2013 and April 2013 have not yet taken place.</p>		

Attachment A
FY 2013-2014 WIC Nutrition Education Plan
WIC Staff Training Plan – 7/1/2013 through 6/30/2014

Agency: Linn County

Training Supervisor(s) and Credentials: Leah Brunson, B.S., IBCLC
Cindy Cole, RD, LD

Staff Development Planned

Based on planned program initiatives, your program goals, or identified staff needs, what quarterly in-services and or continuing education are planned for existing staff? List the in-service topic and an objective for quarterly in-services that you plan for July 1, 2013 – June 30, 2014. State provided in-services, trainings and meetings can be included as appropriate.

Quarter	Month	In-Service Topic	In-Service Objective
1	August 2013	eWIC training	Linn County will serve as a pilot training site regarding eWIC to serve as model for other state agencies.
2	October 2013	Group Nutrition Education Module	WIC staff will complete the latest state produced nutrition education module to enhance PCE skills.
	November 2013	Meeting with Mid-Valley Children's Clinic Lactation Consultants	Further collaboration on providing breastfeeding services to shared WIC clients.
3	January 2014	Baby Behavior eLearning online course	WIC staff will increase knowledge of baby behaviors to enhance parent/guardian understanding of how baby behaviors affect infant nutrition.
	March 2014	Breastfeeding Level 1 eLearning for new WIC staff	Provide initial breastfeeding training to new staff to support WIC's support of improving breastfeeding practices of WIC participants.
4	May 2014	Meeting with Mid-Valley Children's Clinic Lactation Consultants	Further collaboration on providing breastfeeding services to shared WIC clients.
	June 2014	Policy Update	Review updated policies and discuss need to change current policies in order to be consistent in delivery of WIC services.

C. Environmental Health

No updates for 2013-2014

1. The major problem we face is implementing program requirements that are not consistent with real world public health priorities. For example:

- Industry influence seems to exceed that of the general public and regulators, and
- At times, proposed rules, interpretations, or policies are poorly crafted and go beyond legislative intent and authority.
- Responding to poorly crafted rules or policies usurps limited local resources needed to carry out the program. Not responding to proposals risks (what should be) non-starters becoming law or practice.

Our goals are to fulfill the contractual requirements between OHA and Linn County for Environmental Health Services. We conduct the activities necessary to provide program services in all areas of 333-014-0050(2)(e). Evaluations are in the form of the annual Environmental Health Statistics Report, and OHA Triennial Review. Eric Pippert's recent site visit (2009) was a welcomed and useful departure from past practices.

2. Statewide goals, program activities, evaluations and public health priorities are not always in alignment. For example, if one goal is to develop the food protection program in a manner consistent with the FDA Model Retail Food Program Standards, then the annual self-review and triennial review should be completely aligned with and supportive of that goal. The mandatory FDA based field standardization does not mirror our day-to-day inspection procedure. One or the other should change.

An opportunity for regular evaluation of OHA by local health authorities concerning significant state program activities (for example, rulemaking, training, technical assistance, program development efforts and public health priorities) would be welcomed and meaningful if appropriate changes are made as a result. The Drinking Water Program provides a good example of well-articulated goals, pertinent evaluation tools, alignment, and tight integration between state and local efforts.

3. A description of how the program will accomplish the following program requirements. This will, in part, be a description of your management and staffing plan.

- Licensure, inspection and enforcement of facilities under ORS 624, 448, and 446: By complying with the requirements of the statutes.
- Consultation to industry and the public on environmental health matters: By responding to requests based on health significance and available resources.
- Investigation of complaints and cases of foodborne illness: By investigating, tracking and closing all complaints received, and by following the investigative guidelines for foodborne illness.
- Staff access to training and satisfaction of training requirements: At a minimum, staff attends all mandatory training.

Reduction of the rate of health and safety violations in licensed facilities and reduction of foodborne illness risk factors in food service facilities: These reductions will likely come as a result of more effective program management (i.e. alignment with real world public health priorities and needs) at the state level. We faithfully implement all existing program requirements to the full extent allowed within the financial and legal constraints of our contract with OHA.

D. Health Statistics

Linn County preliminary births for 2012 were 946 births and preliminary deaths were 981. The Oregon Health division web site has preliminary 1st births for 2012 at 386. This is down by 44% from 2011 figures. In 2012, we issued 236 birth certificates and 4468 Certified Death Certificates. We enter data into a computer program for death certificates for all deaths for which we produce certified copies. Birth certificate data is directly registered into the State computer system and we download any requested copies and enter intaglio information and orders for certified copies into the computer system. All billing is still done by hand, as that phase of the computer system is still to come. The State computer system for vital stats is OVERS (Oregon Vital Events Registration System).

E. Information and Referral

Linn County is active in maintaining strong partnerships with community resources in order to have current health related information. Through our recent community health improvement plan, we are working on referral pathways with our community partners. All of our information is available in English and Spanish. Over the past year our 211 information and Referral Service has been operational in Linn County. We partner with Benton and Lincoln County on this service. This service has free information about more than 5000 health and community social services. Linn County Public Health is actively involved and listed in this resource.

Linn County Public Health also provides health education information to several school districts with classroom presentations on reproductive health issues. We also provide speakers on special interest topics, working with the local newspaper for coverage and making appropriate referrals as needed and or requested. Recently, we have been working with our mental health department to provide a streamlined system of referrals for our clients needing mental health services.

F. Emergency Preparedness

Linn County's public health ESF8 emergency response plan was rewritten during 2010 and work continues on integrating it with a newly revised county all-hazards emergency response plan. The Linn County Public Health Hazard Vulnerability Assessment was completed with the input from the local health network and city of Albany in June, 2012. Continuity of operations plans are being completed for each department and were exercised in two Table Top exercises. We continue to work with a county multidisciplinary group to plan for special needs populations during an emergency event. The work group is made up of agency's who serve various Linn County residents. Our goals this year are to finalize a draft county Vulnerable Population plan and to aid in the development of emergency plans of group homes with vulnerable populations.

We participated in a full scale exercise with the Local Emergency Planning Group in September, 2012 to test communications with the City of Albany Emergency Operations and the American Red Cross, and the ability of the Linn County Medical Reserve Corps to respond in an emergency. Linn County Health Services participated in a table top exercise in October 2012 to test Continuity of Operations Plans and interdepartmental communications. We continue to test the satellite phones monthly. An increased number of Linn County Health Services Staff became proficient at using the web-based Health Alert Network which allows staff to receive local and state emergency alerts.

New members of the Linn County Medical Reserve Corps were recruited and trained to respond in an emergency. To continue to build a sustainable and robust Medical Reserve Corps (MRC), Linn County applied for and received a MRC VISTA volunteer for 8/2012 to 8/2013.

Linn County Health Services staff completed all the Incident Command System training required of them in their current emergency response positions. We continue to work with an active Local Emergency Planning committee that meets monthly.

Time Period: 2012-2014				
GOAL: Complete work with key partners on the Linn County vulnerable populations plan.				
Objectives	Plan for Methods/ Activities/Practice	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. Compare current emergency plans to needs of vulnerable populations to assess for gaps	As vulnerable populations are identified, their special needs will be compared to the existing emergency plans. Areas where the general population plans do not meet the needs for special populations will be identified in the special needs plan.	Completion of the plan by August 2012.	Draft completed.	Group meets monthly and progress has been made towards this goal. VISTA volunteer finalized draft in August, 2012.

Time Period: 2012-2014				
GOAL: Improve the ability of Public Health to respond to local and state emergencies.				
Objectives	Plan for Methods/ Activities/Practice	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. Assess and evaluate Health Services Departments' Continuity of Operations Plans.	Engage staff to collect current data. Conduct Table Top exercise to practice plans in 2012.	Completed COOP plans and After Action Report to guide future improvements.	Table Top Exercise held October, 2012.	Work continues on TTX improvement items.
B. Review/revise emergency operations plans	Evaluate the Linn County Basic Plan and attached plans and work with the Linn County Emergency Manager to integrate Public Health plans into the county emergency plans.	Compliance during annual program reviews.		Plans are being updated to new county format and progress is being made.
C. Improve surge capacity for public health response.	Continue to recruit and train Medical Reserve Corps members. Work on developing leadership within existing volunteer cadre.	10 new members will be recruited and trained by August 2012. MRC will have identified leaders to help build sustainability.	Recruitment goal met in 2012.	VISTA volunteer helping with recruiting, training, orientation and building sustainability.

Time Period: 2012-2014				
GOAL: Linn County Public Health will participate in a Linn and Benton county wide functional exercise September 2012 with the Local Emergency Planning Committee.				
Objectives	Plan for Methods/ Activities/Practice	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. Participate in planning and preparation for county wide exercise.	Attend planning meetings. Review policies and procedures in preparation for exercise. Update staff training on roles and responsibilities during an event. Update call down list and other critical contact information.	Plans and contact lists will be up-to-date for exercise. Public health will participate in the exercise planning using the HSEEP format as much as possible.	Met in 2012.	Meeting monthly with planning committee.
B. Assist other county departments and other county partners to prepare to participate in the exercise	Encourage and provide support to county emergency management, City of Albany, local hospitals, American Red Cross and Medical Reserve Corps Members to participate in preparing for and participating in the exercise.	County Public Health department will prepare and participate in the exercise with partners.	Met in 2012.	

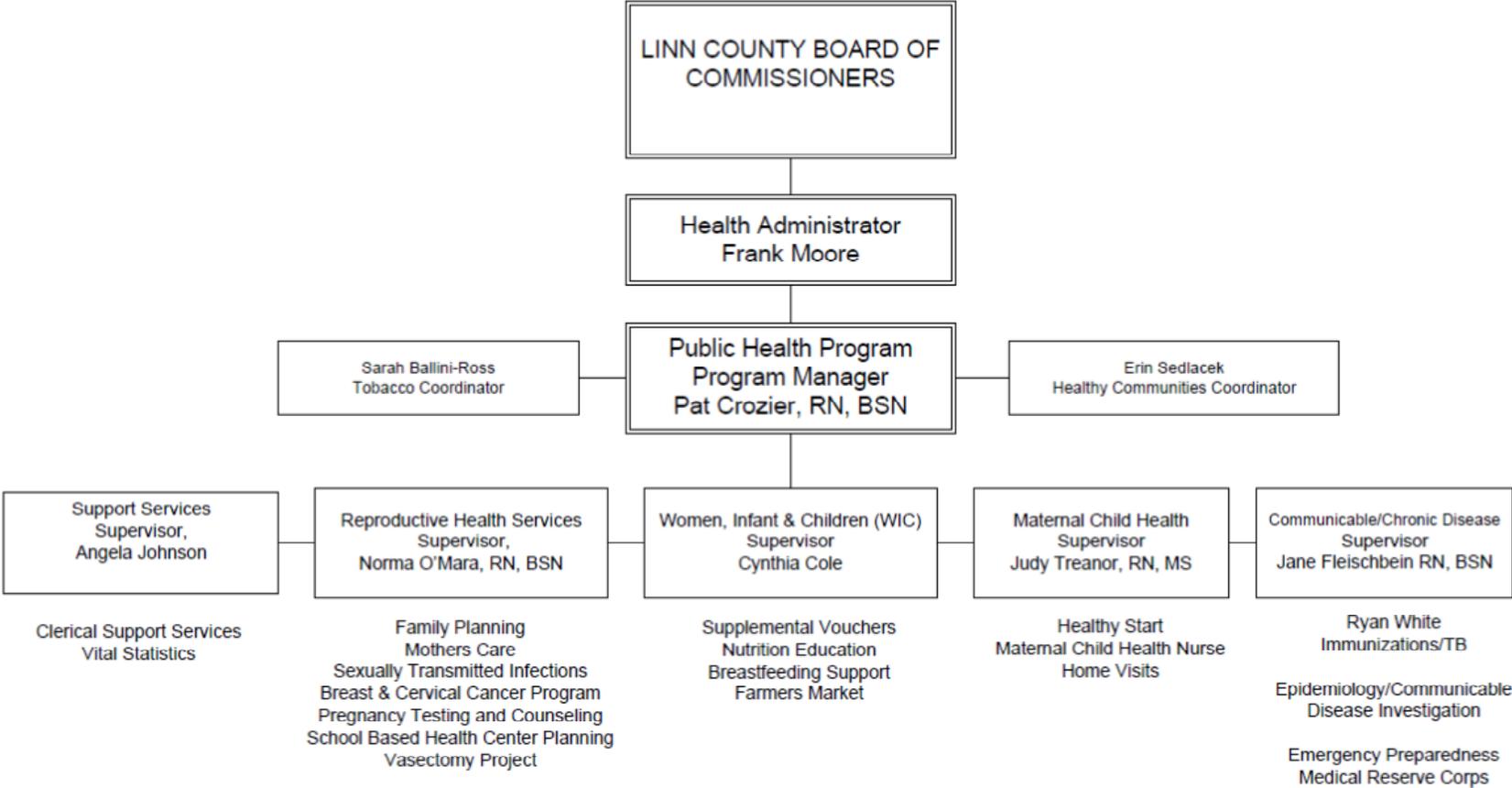
G. Other

HIV Prevention is no longer run out of this clinic.

IV. ADDITIONAL REQUIREMENTS

A. Organizational Chart

**LINN COUNTY HEALTH SERVICES
PUBLIC HEALTH PROGRAM
April 2012**



B. Board of Health

Our Board of Health consists of the three county commissioners. Generally, the Board of Health holds regular meetings on the third Wednesday of the month. During this time the public health program manager, public health administrator, public health medical director, and environmental program manager attend. A monthly report on communicable disease activity, birth and death statistics, and other pertinent health department issues are discussed. These meetings are open to the public and frequently our public health newspaper contact is in attendance.

C. Public Health Advisory Board

The Public Health Advisory Board consists of 7 community members representing a cross section of agencies and private citizens. Currently, there are two vacancies that we will be recruiting to fill. The Health Advisory Board receives information on public health programs, issues, and helps provide suggestions on service delivery. They are a committed group of individuals who take their responsibility seriously. They have recently updated the By-Laws for the Council. They have given good feedback on educational materials for our programs, as well as asked questions about public health threats such as H1N1 and the recent radiation information. We try to update their knowledge on all public health activities so the council can advocate for public health and assist staff in the identification of unmet public health needs. The health advisory council has been active in participating in our recent community assessment work with MAPP as well as Linn County Public Health strategic planning work.

D. Local Commission on Children and Families

Linn County Local Public Health Authority is the governing body that oversees the local commission on children and families.

V. UNMET NEEDS

Linn County Public Health promotes the health and well-being of all Linn County residents. Our county general fund contribution has remained steady over the past two years. We are fortunate to receive up to 37% of our budget from county funds. Over the past year, Linn County public health completed the three pre-requisites for national accreditation. Using the Mobilizing Action through Planning and Partnerships (MAPP) framework along with our partners, Linn County assessed the health status of the county and built a plan to improve priority areas.

The [Community Health Improvement Plan](#) (CHIP) document has shared ownership across all partners of Linn County Public Health and shared responsibility. Results of the Local Public Health System assessment were used to inform the MAPP committee about issues faced with building strong partnerships and mobilizing the community to act on health concerns.

Four topic areas were chosen and prioritized by the MAPP committee based on collected health statistics, survey data, and key informant interviews. These areas are:

- Access to Health Care,
- Tobacco Use,
- Chronic Disease, and
- Substance Use

Resources are a significant barrier. Many of the strategies developed for the CHIP involve seeking funding to implement evidence based programs or partnering with multiple agencies to share cost and employee time.

1. **Access to Services** – In Linn County, 19% of adults do not have insurance. This figure is much higher for the Hispanic population at 45% without health insurance. According to the Linn County Quality of Life Survey, 25% of respondents had a hard time accessing needed health care in the past year.

Transportation creates barriers to access health care. Many rural residents must travel to Albany for many services. Knowledge and awareness of available programs and services is a constant battle in the county. Launching of the 211 Information Line has helped match people with needed services. Public Health will be working on external communication plans to inform citizens about our services. However, with shrinking resources it is difficult to take services to the outlying areas of our county. Several areas to focus on will be looking for federal grants to promote improving the health status for vulnerable populations, understand transit needs and health equity. We continue to partner with In-Reach services for low income residents for acute care as well as Community Outreach.

- 2. Chronic Disease Prevention** – Linn County has a high rate of obesity among children and adults. There is also a low level of exercise and low levels of fruit and vegetable consumption. Linn County has scored low in having strong policy and environmental factors to manage chronic disease.

We continue to support Living Well with Chronic Conditions through Samaritan Hospital. Under our Healthy Communities grant we are working to expand and promote these events as a strategy to reduce chronic disease. Overall, we need to expand on prevention efforts and are constantly looking for grant funds to address this need and expand our health education work. Recently, we are having discussions with our local Coordinated Care Organization (CCO) on how to align public health services with the aim of Health Care Transformation with a focus on prevention.

- 3. Tobacco Use** – Linn County has a high rate of tobacco use compared to both state and national statistics. In Linn county 21 percent of adults smoke, as well as 23 percent of 11th graders and 21% of pregnant women. The 11th grade smoking rate has increased by 64 percent in the past 7 years.

Unlike alcohol and drug abuse, the community does not view tobacco use as a significant health issue. This can present challenges with moving forward on tobacco policies. Our Tobacco Prevention and Education Program along with community partners will address these concerns. Some of the strategies include engaging health care providers in tobacco cessation referrals, increasing tobacco free parks and outdoor areas, and advertising near schools.

- 4. Substance Abuse** – Results from the Quality of Life Survey placed drug abuse as a top health concern in our communities. We have partnered with our Alcohol and Drug Prevention Program as they remain active in the community with Life Skills curriculum. Keys to reducing substance abuse lie with effective interventions that prevent initiation. Funding is in jeopardy for Life Skills in the schools and we have partnered with our Alcohol and Drug program to begin discussion with the CCO on this prevention piece. Again, transportation to access treatment services is a challenge.
- 5. School Based Health Centers** – We continue to be unable to provide school base access to health care for any of our children in Linn County. This is even in light of the alarming rate of asthmas in our school-aged children. There are no current plans for any school based health centers in the coming year.
- 6. Senior Services** – Linn County has a greater percentage of its population over the age of 65 compared to the total population of Oregon. In Linn County approximately 16 percent of the population is over 65 compared to 13.5 percent for the state. This population is one public health has not worked with except to offer flu shots. There are opportunities to help them manage their chronic disease and stay fit and healthy.

We need to partner with Senior and disabled services, our senior centers and Samaritan Health to make sure our seniors don't fall through the cracks. We will be doing a presentation to SHIBA (Senior Health Insurance Benefit Assistants on our services.

7. **Dental** – Oral health is an issue particularly among low socio-economic status individuals. Reports from Samaritan Health Services indicate that in 2011, 554 people accessed the emergency room at Albany Samaritan Hospital for dental services, and 625 individuals used the Lebanon Samaritan Hospital for their oral care. There is a low income children's dental clinic organized by the United Way, Samaritan Albany General Hospital Foundation, Boys and Girls Club of Albany and several local dentist that is located in Albany. Again, geographic location creates a problem with access to care. In the near future the CCO's will take on dental services for Oregon Health Plan clients. It is hard to say what role the county will play. We are part of the Linn County dental coalition and will continue to explore opportunities.

8. **Community Assessment** – The latest County Health Rankings place Linn County 24 out of 33 counties overall. Linn County received funding to complete the community health assessment and develop our community health improvement plan. This funding came from the Performance Management Program at the Oregon Health Authority. The challenge and need is for funds to sustain and coordinate efforts to keep the plan and identified strategies moving forward. Work needs to be done to increase referral pathways in all our programs with the newly formed CCOs. There needs to be a community wide approach to health education and promotion around lifestyle related health issues such as obesity and its negative effects on health. This would include community promotion of healthy choices including nutrition and exercise.

VI. BUDGET

Shirley Wertz is the keeper of our budget information. She can be reached at (541)924-6914 Ext. 2035 and swertz@co.linn.or.us.

Our address is P.O. Box 100, Albany, OR 97321

Please go to www.co.linn.or.us for a complete financial report.

VII. MINIMUM STANDARDS

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

Organization

1. Yes No A Local Health Authority exists which has accepted the legal responsibilities for public health as defined by Oregon Law.
2. Yes No The Local Health Authority meets at least annually to address public health concerns.
3. Yes No A current organizational chart exists that defines the authority, structure and function of the local health department; and is reviewed at least annually.
4. Yes No Current local health department policies and procedures exist which are reviewed at least annually.
5. Yes No Ongoing community assessment is performed to analyze and evaluate community data.
6. Yes No Written plans are developed with problem statements, objectives, activities, projected services, and evaluation criteria.
7. Yes No Local health officials develop and manage an annual operating budget.
8. Yes No Generally accepted public accounting practices are used for managing funds.
9. Yes No All revenues generated from public health services are allocated to public health programs.
10. Yes No Written personnel policies and procedures are in compliance with federal and state laws and regulations.
11. Yes No Personnel policies and procedures are available for all employees.
12. Yes No All positions have written job descriptions, including minimum qualifications.
13. Yes No Written performance evaluations are done annually. **(County policy that after 5.5 years, evaluations are every two years.)**

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

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

Control of Communicable Diseases

37. Yes No ___ There is a mechanism for reporting communicable disease cases to the health department.
38. Yes No ___ Investigations of reportable conditions and communicable disease cases are conducted, control measures are carried out, investigation report forms are completed and submitted in the manner and time frame specified for the particular disease in the Oregon Communicable Disease Guidelines.
39. Yes No ___ Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or communicable disease case received. **(If requested)**
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. **(Available from local pharmacies)**

Environmental Health

47. Yes No Food service facilities are licensed and inspected as required by Chapter 333 Division 12.
48. Yes No Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.
49. Yes No Training in first aid for choking is available for food service workers.
50. Yes No Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided.
51. Yes No Each drinking water system conducts water quality monitoring and maintains testing frequencies based on the size and classification of system.
52. Yes No Each drinking water system is monitored for compliance with applicable standards based on system size, type, and epidemiological risk. **(Public drinking water systems)**
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.**(Public drinking water systems)**
55. Yes No A written plan exists for responding to emergencies involving public water systems.
56. Yes No Information for developing a safe water supply is available to people using on-site individual wells and springs.
57. Yes No A program exists to monitor, issue permits, and inspect on-site sewage disposal systems.
58. Yes No Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.
59. Yes No School and public facilities food service operations are inspected for health and safety risks.
60. Yes No Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12.
61. Yes No A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste.
62. Yes No Indoor clean air complaints in licensed facilities are investigated.
(by public health tobacco program. Work closely with environmental health and have done dual visits.)
63. Yes No Environmental contamination potentially impacting public health or the environment is investigated.
64. Yes No The health and safety of the public is being protected through hazardous incidence investigation and response.
65. Yes No Emergency environmental health and sanitation are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control.
66. Yes No All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448.

Health Education and Health Promotion

67. Yes No Culturally and linguistically appropriate health education components with appropriate materials and methods will be integrated within programs.
68. Yes No The health department provides and/or refers to community resources for health education/health promotion.
69. Yes No The health department provides leadership in developing community partnerships to provide health education and health promotion resources for the community.
70. Yes No Local health department supports healthy behaviors among employees.
71. Yes No Local health department supports continued education and training of staff to provide effective health education.
72. Yes No All health department facilities are smoke free. **(We follow the indoor clean air act and 10' rule.)**

Nutrition

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

Older Adult Health

78. Yes No Health department provides or refers to services that promote detecting chronic diseases and preventing their complications.
79. Yes No A mechanism exists for intervening where there is reported elder abuse or neglect.
80. Yes No Health department maintains a current list of resources and refers for medical care, mental health, transportation, nutritional services, financial services, rehabilitation services, social services, and substance abuse services. (**new 211 referral service**)
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. (**by referral**)

Parent and Child Health

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

91. Yes No Use of fluoride is promoted, either through water fluoridation or use of fluoride mouth rinse or tablets.**(Albany city water fluoridated)**

92. Yes No Injury prevention services are provided within the community.

Primary Health Care

93. Yes No The local health department identifies barriers to primary health care services.

94. Yes No The local health department participates and provides leadership in community efforts to secure or establish and maintain adequate primary health care.

95. Yes No The local health department advocates for individuals who are prevented from receiving timely and adequate primary health care.

96. Yes No Primary health care services are provided directly or by **referral**.

97. Yes No The local health department promotes primary health care that is culturally and linguistically appropriate for community members.

98. Yes No The local health department advocates for data collection and analysis for development of population based prevention strategies.

Cultural Competency

99. Yes No The local health department develops and maintains a current demographic and cultural profile of the community to identify needs and interventions.

100. Yes No The local health department develops, implements and promotes a written plan that outlines clear goals, policies and operational plans for provision of culturally and linguistically appropriate services.**(Currently in the process of developing a strategic plan for Health Department)**

101. Yes No The local health department assures that advisory groups reflect the population to be served.

102. Yes No The local health department assures that program activities reflect operation plans for provision of culturally and linguistically appropriate services.

Health Department Personnel Qualifications

Over the next couple months we will work closely with CLHO to design a survey(s) and questions that will be helpful to the local-state public health system.

In the meantime, answer these questions that measure the LPHA compliance with standards from the Minimum Standards for Local Health Departments.

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: Frank Moore

Does the Administrator have a Bachelor degree?	Yes <u><input checked="" type="checkbox"/></u> No <input type="checkbox"/>
Does the Administrator have at least 3 years experience in public health or a related field?	Yes <u><input checked="" type="checkbox"/></u> No <input type="checkbox"/>
Has the Administrator taken a graduate level course in biostatistics?	Yes <input type="checkbox"/> No <u><input checked="" type="checkbox"/></u>
Has the Administrator taken a graduate level course in epidemiology?	Yes <input type="checkbox"/> No <u><input checked="" type="checkbox"/></u>
Has the Administrator taken a graduate level course in environmental health?	Yes <input type="checkbox"/> No <u><input checked="" type="checkbox"/></u>
Has the Administrator taken a graduate level course in health services administration?	Yes <input type="checkbox"/> No <u><input checked="" type="checkbox"/></u>
Has the Administrator taken a graduate level course in social and behavioral sciences relevant to public health problems?	Yes <u><input checked="" type="checkbox"/></u> No <input type="checkbox"/>

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.

Administrator will continue to look into courses offered to meet the minimum qualifications.

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

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

AND

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

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

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

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

OR

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

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

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

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

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