

# **North Central Public Health District Annual Plan 2013 - 2014**

## **I. Executive Summary**

NCPHD is working hard to continue to serve our communities in the rapidly changing environment at the local, state and federal levels.

Locally, we continue to work to solidify the governance issues surrounding the formation of the first multi-County health district in Oregon. There is a strong commitment on the part of each of the three Counties to maintain the arrangement that is serving each County's interests so well.

We are participating in the Coordinated Care Organizations in our area that were necessary following Oregon's new health care transformation initiative. Both the Director and Deputy Health Officer participate in the group convened by the local Community Mental Health Program Director. We are able to share the value of public health services, and our expertise in assessment and data collection.

We are also very interested in the work around Early Learning in Oregon. The Director has participated in the Home Visiting Design Team work, has followed the Governor's Transition Team Report, worked closely with the Wasco County Commission on Children and Families Director who was a member of the Early Learning Design Team. Earlier this fall, Teri Thalhofer, RN, BSN, NCPHD Director, was named to the Early Learning Council by Governor Kitzhaber.

Nationally, the landscape is ever changing. To adapt to such changes, staff recently completed the Project Public Health Ready Process. This was a valuable method to evaluate strengths and challenges in one program area. We have taken on efforts to prepare for national accreditation for local public health programs through the Public Health Accreditation Board. Efforts to evaluate processes and institute organization wide Quality Improvement is ongoing. We are also upgrading to an electronic medical record and data system. The data system implementation is a massive undertaking that will touch all staff.

We continue to work with our partners in all three Counties to maintain and improve the health of the communities.

## II. Assessment

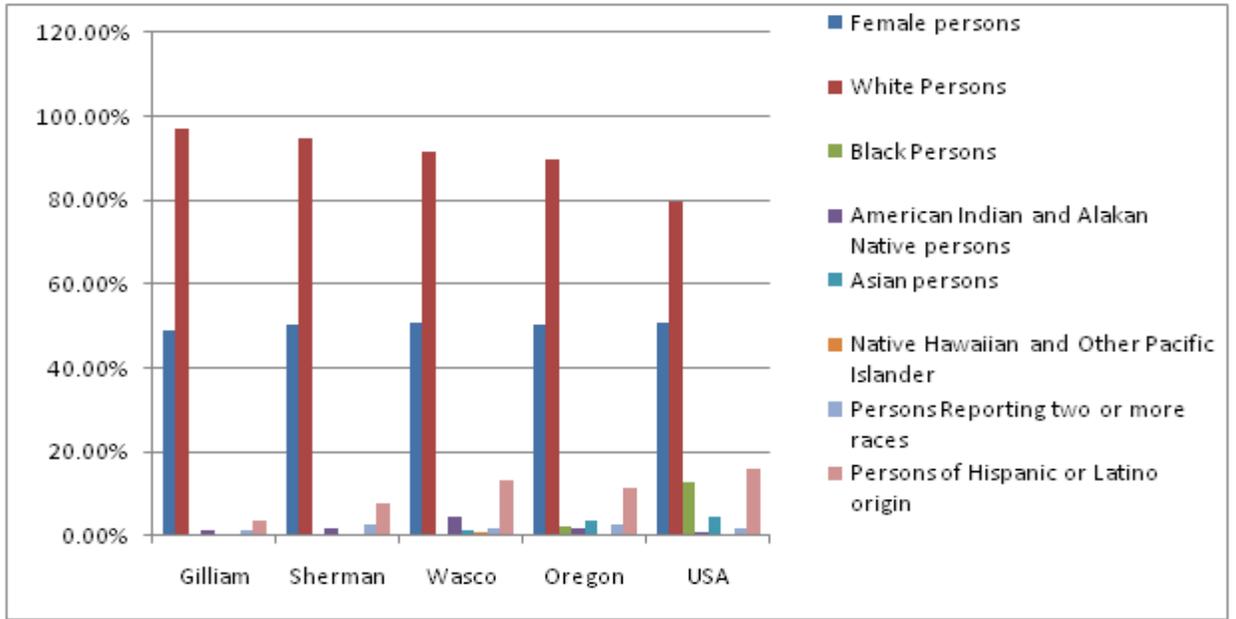
### 1. NCPHD Demographics (Based on 2009 Estimate)

People Quick facts	Gilliam	Sherman	Wasco	Oregon	USA
Population, 2009 estimate	1,645	1,711	24,149	3,825,657	307,006,550
Persons under 5 years old (%)	4.90%	4.60%	6.40%	6.50%	6.90%
Persons under 18 years old (%)	17.80%	18.70%	23.30%	22.80%	24%
Persons 65 years old and over	23.40%	22.30%	17.90%	13.50%	13%
Female persons	48.90%	50.10%	50.50%	50.40%	51%
Persons Reporting two or more races	1.10%	2.70%	1.80%	2.60%	2%
Persons of Hispanic or Latino origin	3.30%	7.80%	13.20%	11.20%	16%
Foreign born Persons	1.70%	2.50%	6.20%	8.50%	11%
Language other than English spoken at home	3.20%	8.00%	10.50%	12.10%	18%
Persons with a disability	362	309	4,299	593,301	49,746,248
Households	819	797	9,401	1,333,723	105,480,101
Persons per Household	2	2	2	3	3

Wasco County is the largest county of the North Central Public Health District (NCPHD). Both Sherman and Gilliam Counties have land area less than 1,205 miles<sup>2</sup>. Wasco County is significantly larger, 2,381 miles<sup>2</sup>. Wasco County has the largest population size (24,149 Census). Sherman and Gilliam counties have population sizes significantly lower than Wasco. Sherman County has a population of 1,711 and Gilliam having 1,645. The NCPHD office is located in The Dalles in Wasco County. The location of the health office reflects the population data. It makes most sense to have the clinic where the majority of people are located.

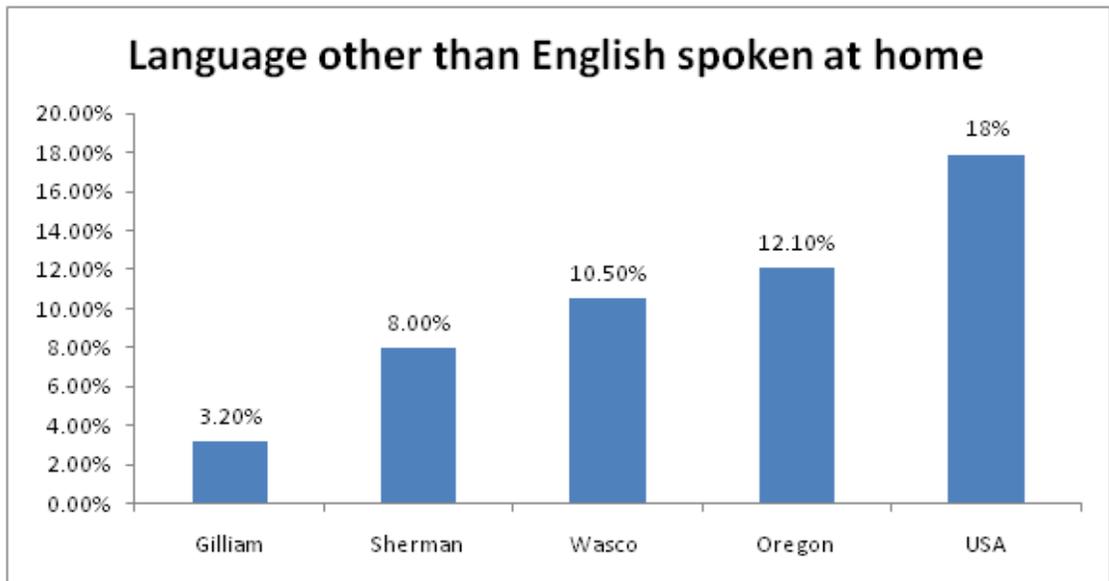
#### *Ethnicity*

The demographics of a population vary significantly depending on your location. Figure below shows a comparison between the three counties, Oregon, and the United States. This data represents the race of the designated population area. All three counties have the highest population of white persons, and Asian persons coming in second. This data parallels the demographic data for both Oregon and the United States.



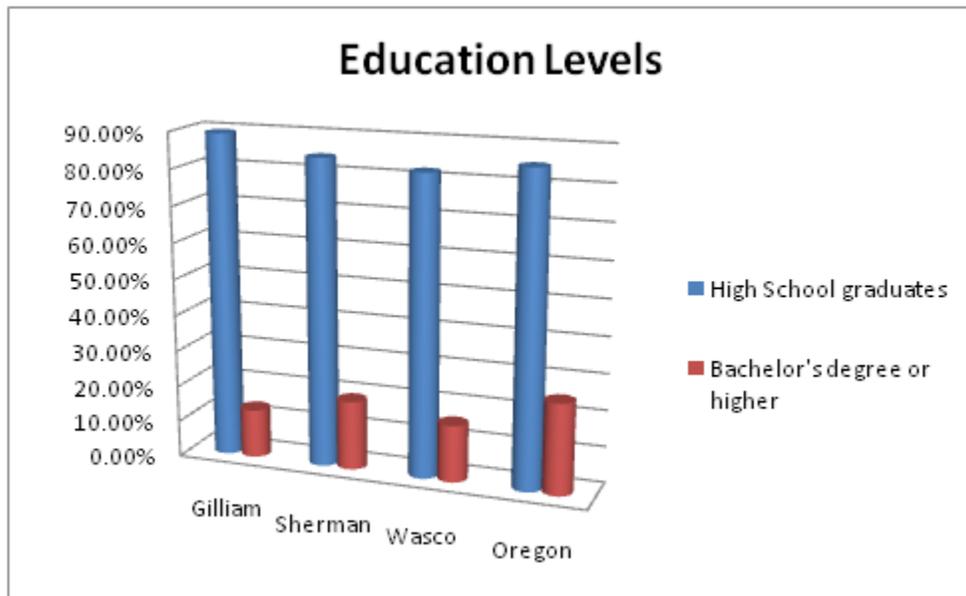
*Language*

NPCHD focuses on providing all information in both English and Spanish. Some employees are bilingual to help assist people as well. Language barriers can create barriers between communities. It is important to prevent these barriers from forming. These barriers can create disparities in healthcare (Boston Medical Center). Wasco County has the highest percentage of people speaking a language other than English in the home as noted in figure below. Providing multiple languages for information is helpful for reaching out to the community. This helps the community members stay more informed and feel more comfortable. Community outreach plays a pivotal role in making our health department successful.



### *Education*

As of 2000, the percentage of people above age 25 graduating high school was above 82% percent in Gilliam, Sherman, and Wasco Counties. The percentage of people, who earned higher than a Bachelor's degree, as of 2000, was less than twenty percent in all three counties. Sherman County had the highest percentage (19%) of people receiving a Bachelor's degree or higher. The level of education that a person completes has a direct relationship on income potential. People who continue college to receive professional degrees make the most money. (Baum)



### *Income*

Per capita income across all three counties is approximately 17% lower than the State Average, yet rural residents often pay higher prices for groceries and gas, and often drive more miles for work and other services. In Oregon, 13.5 % of citizens live below the poverty level, whereas in Wasco, Sherman and Gilliam Counties, 17.1%, 15.5% and 11.1% are below the poverty level.

### *Migrant Workers*

There are many factors that restrict migrant and seasonal farm workers' access to health care (Melt). These factors include a combination of cultural and linguistic barriers, limited economic resources, and distrust of outsiders. A great percentage of migrant workers and their children are uninsured. Migrant workers often involve complicated cases due to language and citizenship. These obstacles can be difficult to overcome.

### *Homeless*

In the three county area served by NCPHD, there are many people who are living below the poverty level. Living below the poverty line poses many problems for these people. Not all of the people who are living under such circumstances have a home. These people struggle not only with finding shelter but also finding food to eat. These homeless persons have an extreme lack of all types of resources that most people take for granted, such as instant access to shelter, telephones, and the media. In a recent survey it was determined that there are roughly 500 homeless in the NCPHD region. These people are also a vulnerable population that should be thought of and planned for in case of an emergency.

### **Community Health Assessment**

North Central Public Health District was funded in 2010 through the Oregon Public Health Division to complete a community health assessment and create an implementation plan. The Community Health Assessments for the three counties served, which included Gilliam, Sherman and Wasco Counties, were completed in June 2011.

The main objective of this Healthy Communities Program is working to engage communities and mobilize national networks to focus on chronic disease prevention. The Community Health Assessment focused on three main sections. These sections include community organizations/institutions, worksites, healthcare, and schools. By assessing places that people spend most of their time within their community, the assessment provides a community wide approach to focus on chronic disease prevention.

The Community Health Assessment and Group Evaluation (CHANGE) tool was designed by the CDC to:

- Identify community strengths and areas for improvement.
- Identify and understand the status of community health needs.
- Define improvement areas to guide the community toward implementing and sustaining policy, systems, and environmental changes around healthy living strategies (e.g., increased physical activity, improved nutrition, reduced tobacco use and exposure, and chronic disease management).
- Assist with prioritizing community needs and consider appropriate allocation of available resources.

## **Community Health Assessment Results**

This document compiles the results of all three counties within the North Central Public Health District (NCPHD) for a summary of all sectors of the Community Health Assessment. NCPHD strives so that one day all people will live in a safe environment free from fear of preventable diseases; that all businesses, organizations and individuals will have access to health information and have the desire to promote and be responsible for a healthy lifestyle for themselves and each other.

### *Community Institutions/Organizations*

There were four community institutions that participated in the assessment. These four institutions are providing service to 75-2,000 people. They are all located in rural areas, and are an array of public and private, non-for-profit organizations. The highest strength area overall occurred in “Tobacco Use” for these agencies. On the contrast the overall weakness was in the “Leadership” section. These averages are directly related to both the policy average and the environment average of the organization. “Leadership” took the low across the board for community institutions and organizations. This includes lows in environment, and policies.

### *Worksites*

Worksites included in the assessment encompassed a range of different demographics. The worksites studied employed anywhere from 20- 999 people. These worksites were a combination of both public and private, and non-for-profit and for profit. In total four worksites were participants of the assessment. Worksites showed their strengths in “Chronic Disease Management.” The strengths in “Chronic Disease Management” go across the board for both policy and environment. Worksites seemed to have an overall average low in “Physical activity.” However they also showed a weakness in the environmental aspect of “Leadership.”

### *Healthcare*

The healthcare facilities studied in the assessment were both private and public establishments. They also differed greatly in their type of profit profile. Some businesses were non-profit and others were for profit. The establishments ranged from having less than twenty employees to 500. These businesses do their best to provide care to all residents in the NCPHD. These healthcare facilities serve over 1,500 people a month combined. All six healthcare participants showed the highest strength in “Chronic Disease Management.” They also showed a high in

environmental “Nutrition.” Therefore these agencies are striving to create health nutrition options on site. The overall weakness of these healthcare providers was “Physical Activity.” The assessment also showed that there needs to be a high focus on creating an environment with more “Chronic Disease Management.”

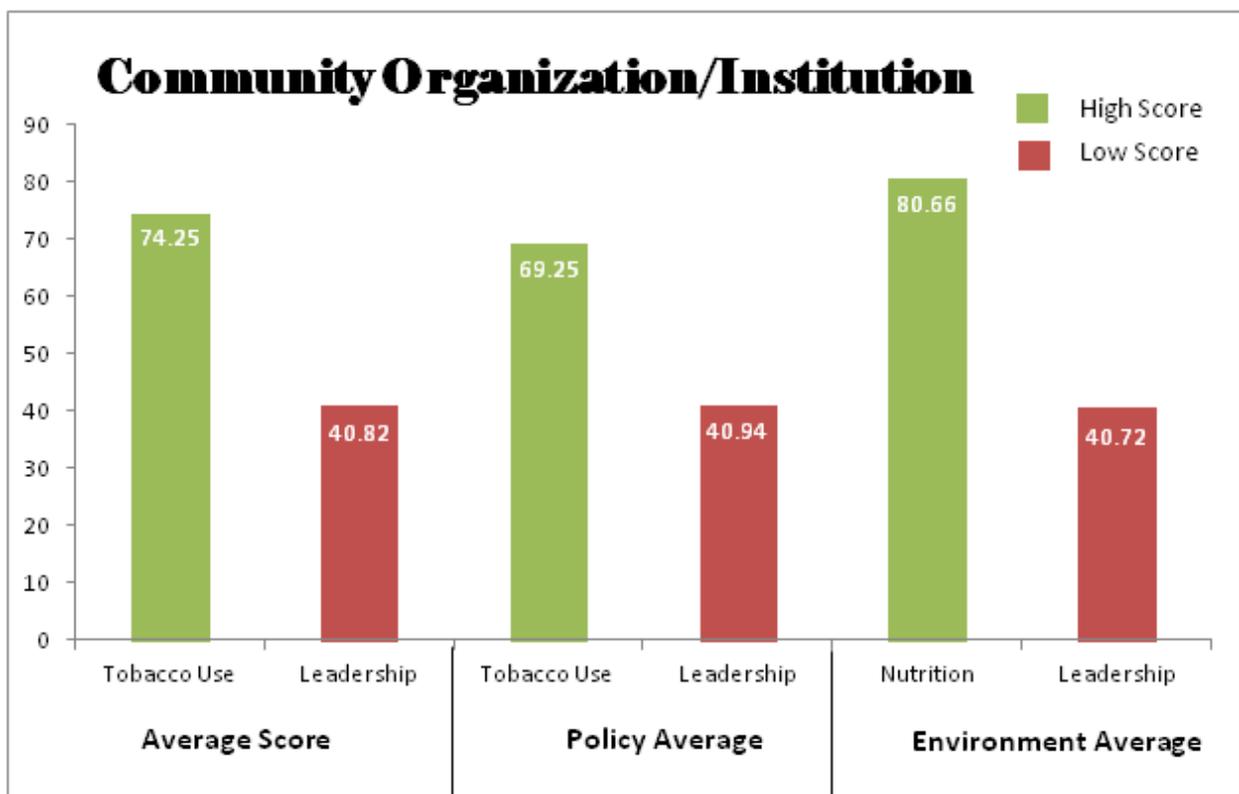
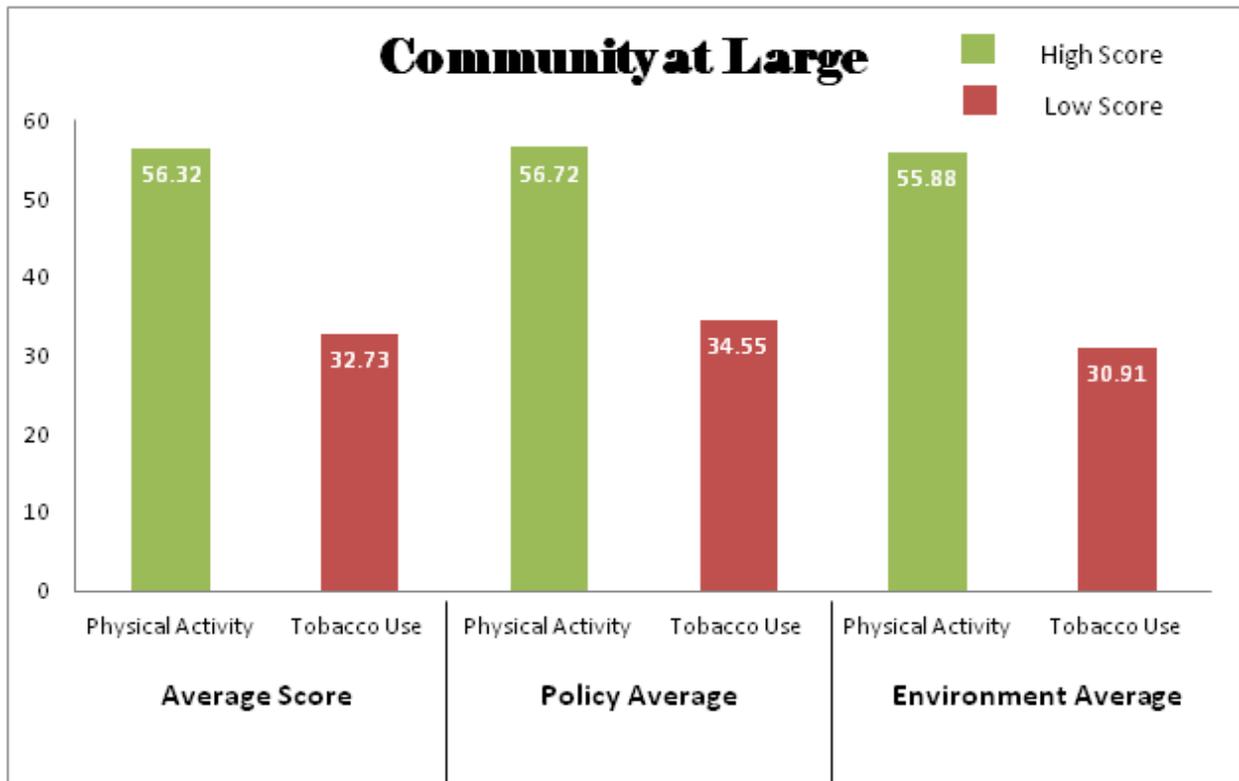
### *Schools*

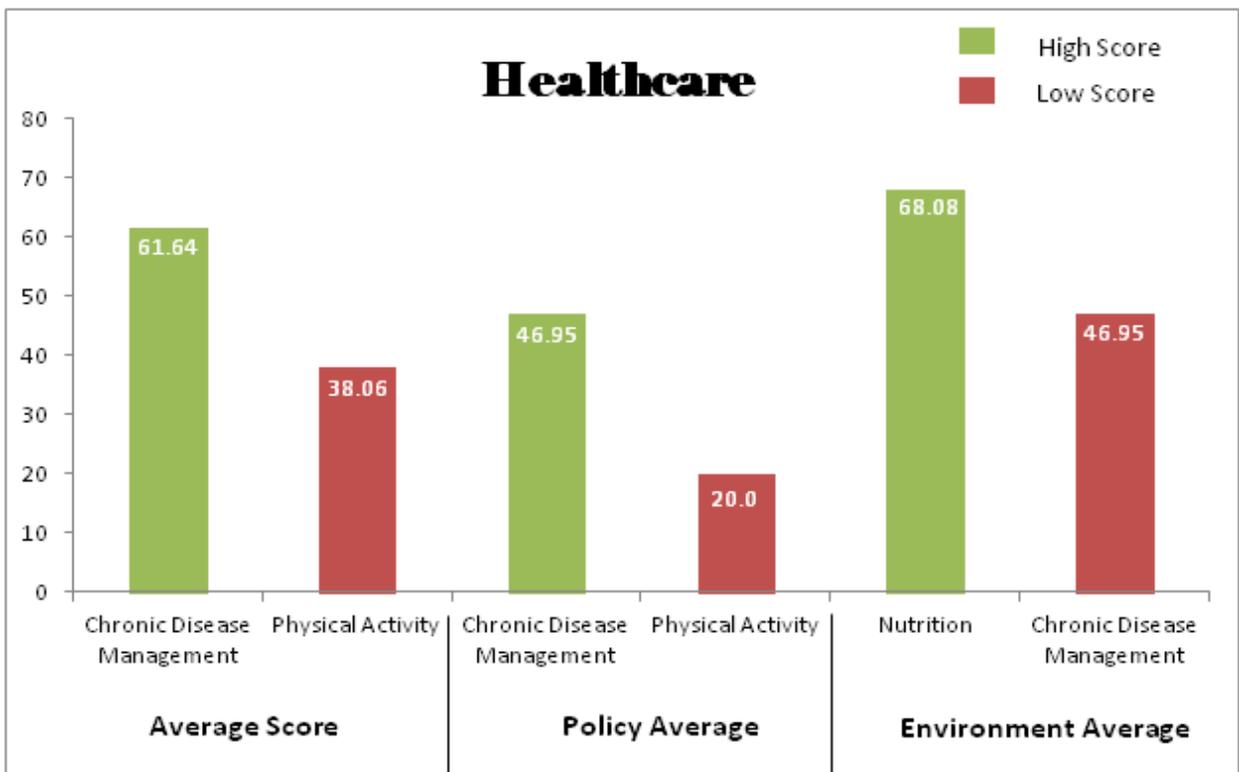
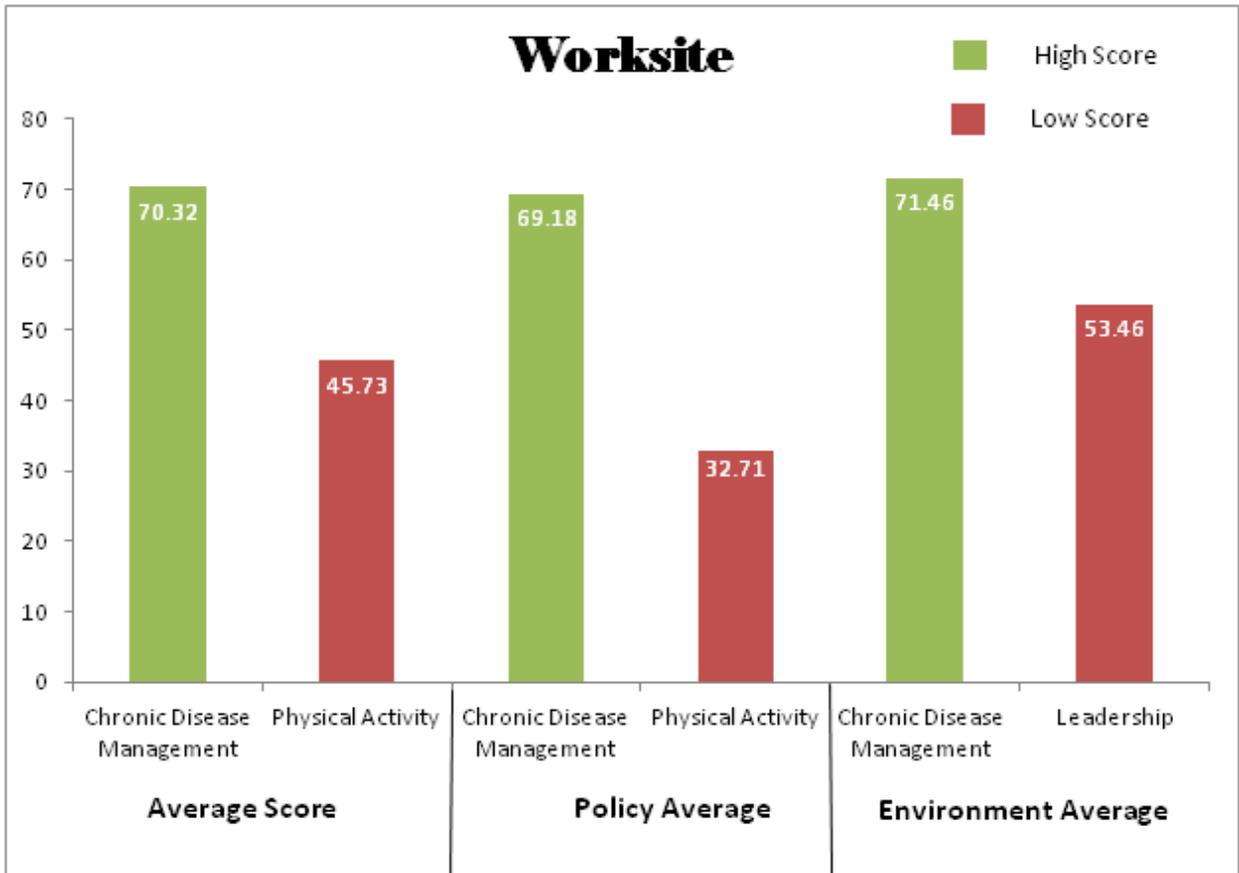
The schools that participated in the assessments were public schools; most districts chose one school to participate in the evaluation. Selected school’s enrollment varied from 117-440 students. The median household income within the districts ranged from \$35,430 to \$46,709. The districts varied, having between 1-5 schools in the district. School had higher scores across the board than any other institution that was assessed. This may be a reflection of the amount of regulations that schools must follow. The highest average score within the seven factors affecting chronic disease were in the category of “School District.” This part of the assessment looked primarily at various regulations within the district and it spanned the other categories of physical activity, nutrition, chronic disease management, tobacco and leadership. The questions were pertinent to the position the school takes to support health in students. The lowest average score within the seven factors assessed, for schools, was in the “After School” section. This may be due to the fact that after school care is not the primary function of schools, and perhaps it is not as thoroughly regulated as other aspects the school offers.

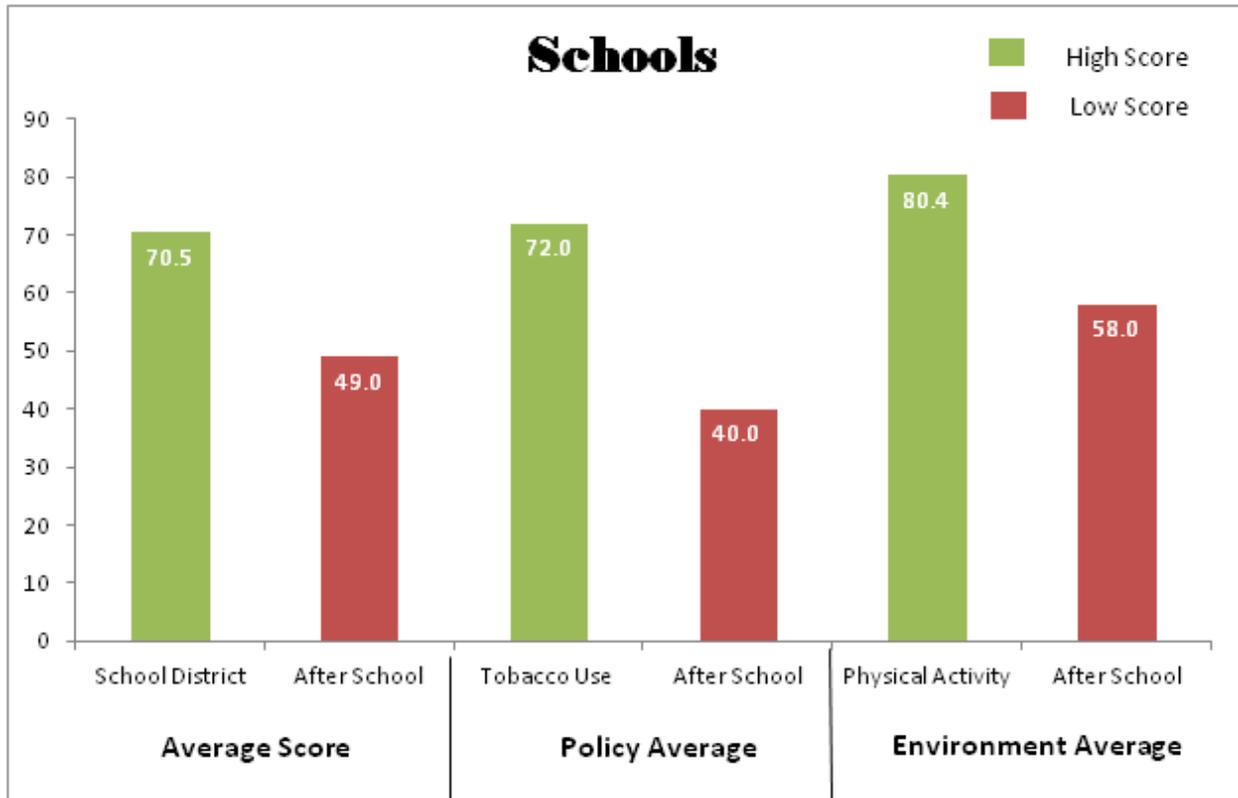
One of the key findings of our Community Health Assessment and Group Evaluation (CHANGE) assessments were school districts fared better than any other sector. Almost all of the schools have incorporated salad bars during all lunches, and may also feature fresh fruits. Existing policies and laws dictate certain minimum standards for schools (example, school lunches). After school programs were the lowest scores for the schools.

Across the board policy scores were typically lower than environmental scores, and leadership averaged behind all other target areas. This could point to some general areas we need to focus on within our communities in the implementation phase. The assessment showed us where our strengths and areas for improvement are, while understanding the community’s needs.

*Community Health Assessment Data Average for Wasco, Sherman, Gilliam Counties*







### What's next?

We discussed the results of the assessment within our CHART. We discussed offering policy templates when appropriate, as well as Chronic Disease Prevention Leadership training. Our districts need for Leadership was enhanced our Coalition Training that took place on July 19, 2011. NCPHD hope to further fulfill our needs as well as our surrounding community and offered Quality Improvement Training in November 2011.

Themes that emerged from the community assessments included:

- Everyone agreed that health is important, but not everyone agrees on how it should be achieved.
- Lack of Tobacco Quit Line resources available
- Employee benefit packages include tobacco cessation resources but they are not promoted
- Complaints about current tobacco policy and who should be enforcing the Indoor Clean Air Act
- Opportunity for coalition to support TPEP efforts
- Most people welcomed Chronic Disease Self Management promotional materials being made available or distributed through their organizations. Health promotion activities available with the Area Agency on Aging, La Clinica and The Next Door to help promote Living Well within the various organizations.

- Workplace wellness activities were minimal to non-existent in the community assessments. Some people remembered having pedometers, and brief periods when they had garnered enthusiasm around physical activity, but none had ongoing programs devoted to employee health. On a positive note, there seemed to be an interest on the part of employers to consider Workplace Wellness improvements, and because this area has been proven to pay for itself in the long run, it may be easier to promote within our region. Our CAP identified many strategies to improve nutrition, physical activity, chronic disease prevention and tobacco-use reduction in the workplace, so an overall ‘workplace wellness’ theme may be emerging as an over arching strategy to promote within the communities.

A Healthy Communities Work Group of North Central Public Health District has been formed from CHART member participants. These members are a diverse group of people representing various sectors of the community with an interest in the ultimate well being of their community. The group has been meeting since the beginning of the year. They have already divided up brainstorm strategies and self-identified areas where their strengths and interest lie. The group met on July 21, 2011. At this meeting they worked to direct their focus on physical activity first. The areas of focus to follow are nutrition, tobacco, and chronic disease management.

The Healthy Communities Work Group posses the desire and commitment to improve the opportunities for optimal health of all citizens, a community that has low cost or no cost options for physical activity, has abundant availability of affordable healthy foods, in an environment where it is easy to be tobacco free and where all citizens are empowered with the knowledge to reduce the incidence and impact of chronic diseases.

## **2. Local public health services**

NCPHD exists to prevent disease and injury, promote healthy behavior, and protect the public and their environment.

In general NCPHD enjoys strong support from community partners.

**3. NCPHD assures the five basic services contained in statute (ORS 431.416) and rule.**

**a. Epidemiology and control of preventable diseases and disorders;**

Staffing remains stable with experienced CD staff in place. Collaboration between CD and EH remains strong for investigation as well as community outreach to enhance prevention.

NCPHD has continued outreach and education to providers and the local hospital regarding CD reporting and best practice as outlined OAR Chapter 333. Worked closely with the hospital and recently developed and implemented new Notifiable Communicable Disease Reporting Form to improve overall reporting process for both the reporting agency as well as the local health department.

Chlamydia remains by far the most common reportable disease in Wasco, Sherman and Gilliam County's.

Communicable Disease case counts by county of residence:

[http://www.wshd.org/wshd/pdfs/dis\\_county.pdf](http://www.wshd.org/wshd/pdfs/dis_county.pdf)

**b. Parent and child health services, including family planning clinics as described in ORS 435.205;**

Maternity Case Management (MCM), Babies First! (BF!), and Community Based Care Coordination (CaCoon) are coordinated by Jane Palmer, RN, BSN. Jane joined NCPHD as Nursing Supervisor/Clinical Programs Manager in October of 2012. Staffing the programs in rural Wasco County, Sherman County, and Gilliam County are Dianne Kerr, RN, BSN and Eloise Mortimore, RN. Nancy Hammel, RN, BSN and Lori Treichel, RN, BSN, serve families living in The Dalles area.

NCPHD's relationship with NCESD and has allowed for greater coordination in Gilliam and Sherman Counties, especially. NCESD is the Healthy Start contractor for those counties, and we contract with them for Eloise to provide the home visits.

*Successes* in the program include an integration of services with WIC and Home visiting staff and increased coordination with Early Intervention around audiology screening for newborns at risk for hearing loss.

During the year Babies First and Caccoon forms have been revised to decrease the amount of duplication and have greatly decreased the amount of time charting as noted in two time studies.

We are currently working to increase the efficiency of the home visiting programs by integrating a Community Health Worker who is bilingual in Spanish and bicultural with the local Hispanic Community.

We are also working closely with community partners in the area to ensure discussion and coordination around the “Community Based Coordinators of Early Learning Services”.

**c. Collection and reporting of health statistics;**

## Family Planning in Wasco County 2010

<b>Clients served</b> .....	<b>1,138</b>
Female .....	<b>1,123</b>
Male .....	<b>15</b>
Teens .....	<b>319</b>
Hispanic .....	<b>382</b>
Racial minorities .....	<b>39</b>

### **Women In Need of publicly funded contraceptive services and supplies .....1,475**

Women In Need (WIN) are between 13 and 44 years old, fertile, sexually active, neither intentionally pregnant nor trying to become pregnant, and at an income below 250 percent of the federal poverty level (FPL). Women In Need may require public assistance to get services and avoid unintended pregnancy.

**Percentage of Women in Need served .....74.2%**

**Teen pregnancy rate (15- to 17-year-olds) ..... 25.6 per 1,000**

(Teen pregnancy rate in 2008 is the same as 2010 with a rate of 25.6 per 1,000)

### **Access**

**Clients benefiting from public investment in family planning dollars\* ..... 861(76%)**

\*Includes clients covered by Title X and Oregon Contraceptive Care (CCare) monies.

Free or low-cost services are available for these clients to reduce barriers to care.

**Clients with limited English-language skills .....135**

Most family planning clinics have Spanish-speaking staff, offer culturally appropriate services, and produce client materials in Spanish and other languages.

Family planning clinics reach Oregonians who traditionally have difficulties getting services they need. These underserved clients include low-income clients, those in rural communities, who are incarcerated, those with limited English-language skills, and many others.

### **Services and connections**

**Cervical cancer screenings conducted .....413**

**Tests for sexually transmitted diseases provided .....388**

**Contraceptive counseling sessions delivered .....2,080**

**Referrals offered (e.g., mammography, other medical services, prenatal, social services) .579**

### **Economic and social benefits**

**Dollars leveraged in federal funds for CCare .....\$168,811**

**New clients receiving a more effective birth-control method .....23%**

**Unintended pregnancies prevented .....220**

Estimated taxpayer savings in prenatal, labor and delivery, and infant health care costs for every unintended birth prevented by the Oregon Reproductive Health Program is about \$9,450.

## **d. Health information and referral services; and**

There are no substantial changes in the area of Information and Referral.

#### **e. Environmental health services**

The function of North Central Public Health District Environmental Health Program is to identify health risks in the environment and implement or promote solutions that eliminate or reduce risk. This includes investigation and containing diseases and injuries to reduce the incidence of contagious diseases, and reduce the disabilities related to disease and injury.

The Environmental Health (EH) program covers three counties: Wasco, Sherman and Gilliam and currently the EH program currently is fully staffed with 3.0 FTE Environmental Health Specialists (EHS).

#### **4. Other issues**

##### **Accreditation**

*NCPHD has been working towards accreditation with intent to apply by June 2012.* Accreditation signifies that the best possible services are being offered to keep our communities healthy. With accreditation status NCPHD will be able to demonstrate increased accountability and credibility to the public. Our expectation is that accreditation will strengthen the district and the services provided, which will contribute to improved health outcomes in our communities. We are happy to report that our application for accreditation was submitted June 27, 2012. We continue to work to submit necessary documentation.

NCPHD hosted training in November 2011, “Quality Improvement & the Move to Accreditation.” The training was funded by a grant obtained from Northwest Health Foundation and NCPHD. Dr Ray Nicola, MD, MHSA, FACPM, Senior Consultant and CDC Assignee to Northwest Center for Public Health Practice and currently serves on the Board of Directors of PHAB was the presenter and lead us in the exploration of the many facets of continuous quality improvement and how to link to PHAB accreditation prerequisites. Attendees included Public Health Directors from various Oregon Counties, County Accreditation Coordinators, AmeriCorps Vista’s, etc.

All NCPHD Policies and Procedures continue to be reviewed and updated.

*“The RPI helped the group to develop new process improvement skills and get energized about identifying and improving other obvious process problems in the clinic.” – Teri Thalhofer, R.N., NCPHD Director*

**RPI members**

- Matt Mercer, Patient Registration
- Grace Anderson, R.N., Public Health Nurse
- Teri Thalhofer, R.N., Director
- Tracy Willett, M.D., Health Officer
- Mary Catherine Clites, R.N., Nursing Supervisor

## Quality improvement success stories

### Local spotlight

#### NCPHD: Improving patient care in a family planning clinic

In August 2011, the North Central Public Health District (NCPHD) convened a Rapid Process Improvement (RPI) team to decrease the wait time of family planning clinic clients. Staff identified two reasons to improve the current process: 1) to reduce the client wait time to be seen by a nurse practitioner; and 2) to reduce the length of appointments (returning patient appointments took 30 minutes and new patient appointments required 45 minutes).

After conducting informational interviews with NCPHD staff, a two-day RPI was planned to create a process that would allow the family planning clinic to serve more clients in the same amount of time, without sacrificing quality. The event objectives were to understand the current process, look for areas where it could be improved, and develop a new standard process for client exam flow.



*The NCPHD RPI team (clockwise from top left): Mary Catherine Clites, Tracy Willett, Matt Mercer, Grace Anderson (not pictured: Teri Thalhofer)*

The group created a value stream map, with agreed upon “essential categories of work that needed to be done” in order for the process to work. Once root causes were defined, they were able to mitigate the cause with the right improvement. Then the group constructed new process maps.

Currently NCPHD is pilot testing the new process and measuring the impacts of the improvements.

NCPHD completed the PPHR application criteria were submitted in September 2011. Results are not available as this time.

Project Public Health Ready (PPHR) is a competency-based training and recognition program that assesses preparedness and assists local health departments, or groups of local health departments working collaboratively as a region, to respond to emergencies. It builds preparedness capacity and capability through a continuous quality improvement model. The PPHR criteria are the only known national standards for local public health preparedness and are updated annually to incorporate the most recent federal initiatives. Each of the three PPHR project goals—all-hazards preparedness planning, workforce capacity development and demonstration of readiness through exercises or real events—has a comprehensive list of standards that must be met in order to achieve PPHR recognition.

### **III. Action Plan**

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

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

*Current Condition*

Staffing remains stable with experienced CD staff in place. Collaboration between CD and EH remains strong for investigation as well as community outreach to enhance prevention.

NCPHD has continued outreach and education to providers and the local hospital regarding CD reporting and best practice as outlined OAR Chapter 333. Worked closely with the hospital and recently developed and implemented new Notifiable Communicable Disease Reporting Form to improve overall reporting process for both the reporting agency as well as the local health department.

Chlamydia remains by far the most common reportable disease in Wasco, Sherman and Gilliam County's.

HIV Case Management is now provided in the District by EOCIL through a contract with OHA. We actively refer to their program and work cooperatively with staff.

Communicable Disease 2010 case counts by county of residence:  
[http://www.wshd.org/wshd/pdfs/dis\\_county.pdf](http://www.wshd.org/wshd/pdfs/dis_county.pdf)

North Central Public Health District					
Report Disease by Year					
Disease	Year				
	Includes Wasco/Sherman/Gilliam Counties Jan-Aug				
Year	2007	2008	2009	2010	2011
Campylobacter	5	4	5	5	4
Chlamydia	64	61	71	69	57
Cryptosporidium	0	0	0	2	0
E. coli (STEC)	0	0	1	2	0
Giardia	1	0	2	1	6
Gonorrhea	8	4	1	5	0
Hep B (acute)	0	0	3	1	2
Hep B (chronic)	4	2	4	5	4
Hep C (acute)	2	1	0	0	0
Hep C (chronic)	65	37	26	38	25
HIV	3	2	3	2	2
HUS	1	0	0	1	0
Legionella	0	1	0	1	0
Listeria	1	0	1	0	1
Lyme	0	1	1	0	0
Malaria	1	0	0	0	1
Meningitis	0	2	1	0	0
Pertussis	0	0	1	0	2
Q fever	0	0	1	1	0
Rabies (animal)	0	1	0	0	0
Salmonella	3	4	4	5	1
Shigella	7	0	0	0	0
Syphilis	1	0	0	0	0
Taeniasis	0	1	0	0	0
TB	0	0	0	1	0

*Goals-for Gilliam, Sherman and Wasco County's*

1. Identify, prevent and decrease endemic and emerging communicable and environmentally related diseases.
2. Vaccinate against vaccine-preventable diseases
3. Educate the public regarding communicable disease prevention
4. Educate providers and improve communicable disease reporting practices
5. Continue the ability to receive and respond to communicable disease reports and public health emergencies 24/7

### *Activities*

1. Provide epidemiologic disease investigations to report, monitor and control communicable diseases and other health hazards
2. Provide consultative communicable disease services
3. Assure early detection, education and prevention activities to reduce the morbidity and mortality of reportable communicable diseases
4. Assure the availability of immunizations for human and animal target populations
5. Collect and analyze communicable disease data and trends for program planning and management to assure the health of the public
6. All public health nurses are trained in communicable disease control and are provided fit testing
7. Educate providers and improve communicable disease reporting practices
8. Continue communicable disease education in community settings and with community partners

### *Evaluation*

1. Number of days between receipt of case reports at the county and receipt of case reports at the State, as described in the monthly communicable disease surveillance report as a marker for timely reporting from the local health department to the state
2. Number of elements missing from Orpheus encounters
3. Meeting the Conference of Local Health Officials Minimum Standards for reportable Communicable Disease Control, Investigation and Prevention
4. Results of CQI
5. Compliance criteria met during the Triennial Program Review was conducted by the Oregon Department of Human Services

## **2. MCH Program**

### *Maternity Case Management (MCM)*

MCM goal assist pregnant women in accessing prenatal, social, economic, nutritional and other community services. Program goals are achieved through

nurse home visits which are individualized to identify and address each client family's needs and goals.

### *Babies First*

Babies' First goal is to improve the physical, developmental and emotional health of high risk infants. To achieve this goal there are four objectives: to improve the early identification of infants and young children with the risk of developmental delay; assist families to access the appropriate community resources; standardize the public health nurse's ability to assess development and yearly analysis of outcomes data.

### *CaCoon Program*

CaCoon program goal is to provide public health nurse care coordination services. The CaCoon program provides specialized training to nurses in order to make them confident resources in their communities. In this manner accurate information is provided to families; access to community services is improved; efficient use of health care and service systems is promoted and well-being of Children & Youth with Special Health Care Needs (CYSHN) families is promoted.

### *Challenges*

Limited MCM services are provided due to the lack of nurse personnel. A .6 FTE nurse was hired to provide relief staffing in the clinic 4 weeks ago and the plan is to transition her to provide MCM services to Gilliam and Sherman Counties one day per week in the next 3-4 months.

### *Successes*

The Babies First and CaCoon nurses have been part of the NCPHD for many years. Both have excellent working relationships with community partners and are well known, trusted and respected in all three counties.

### *Goals for Gilliam, Sherman and Wasco County's*

1. Train new public health nurse to see MCM clients one day per week.
2. Decrease teen pregnancy rates
3. QI/QA activities

### *Activities*

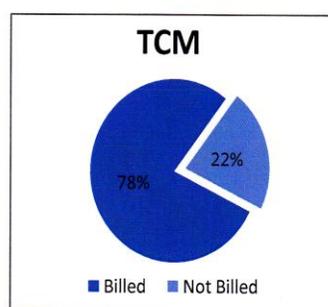
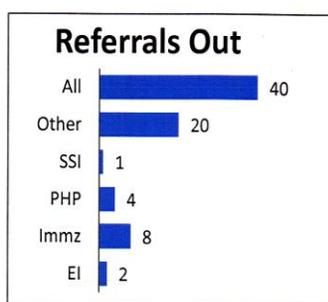
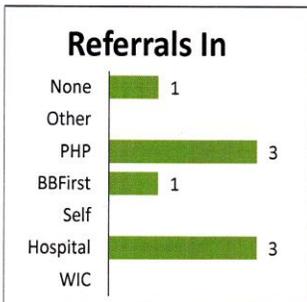
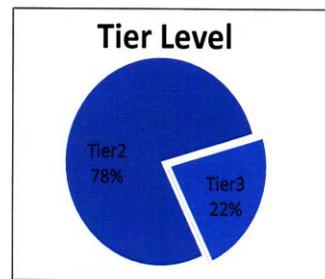
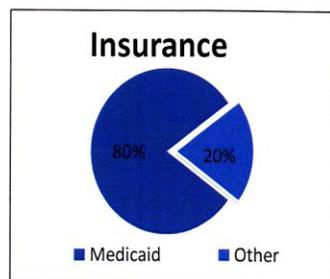
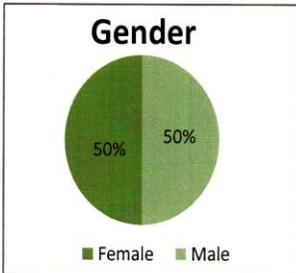
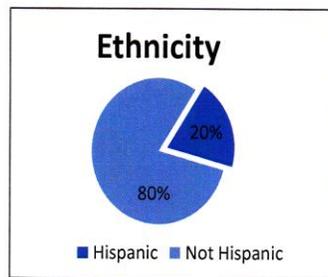
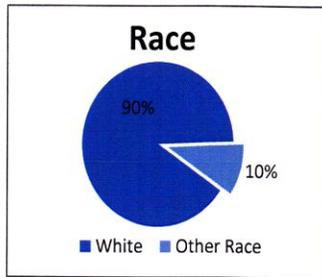
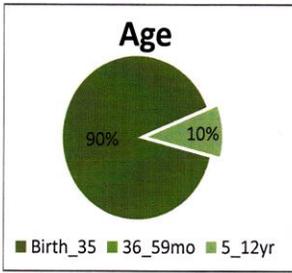
1. Provide community education regarding teen pregnancy
2. Consult with community partners to identify solution for increase in teen pregnancy rates
3. Provide education and BCP options in schools

*Evaluation*

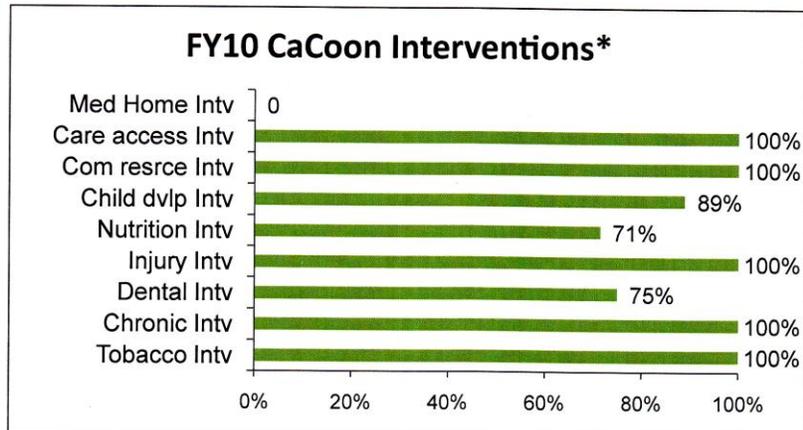
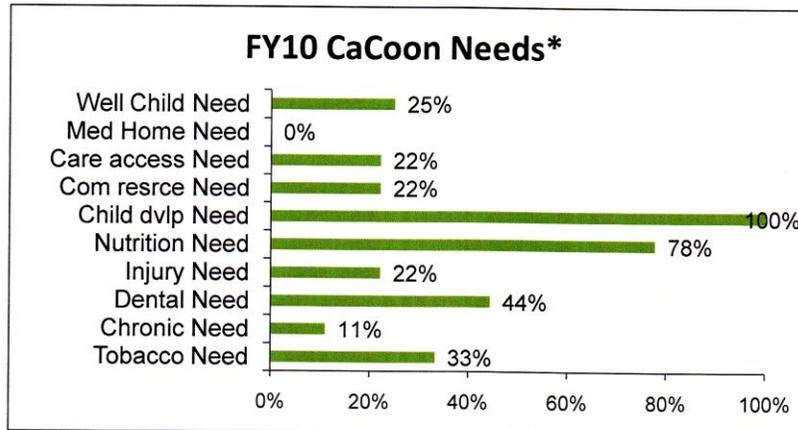
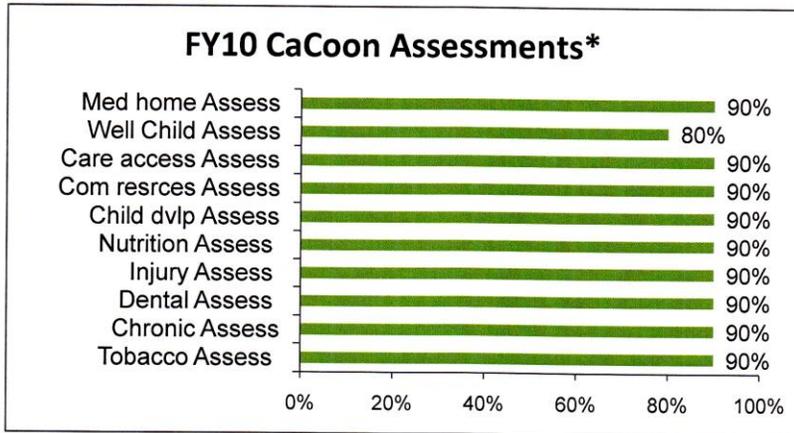
1. Identify and implement evaluation criteria

## North Central Public Health District: FY2010 CaCoon

<b>Children Served:</b>	10	<b>Central Region Children served:</b>	93
<b>Child Visits:</b>	46	<b>Central Region total visits:</b>	381
<b>Average visits:</b>	5	<b>Central Region average visits:</b>	4
<b>Providers:</b>	2	<b>Central Region providers:</b>	11



## North Central Public Health District: FY2010 CaCoon



## Oregon Mother's Care Data

**Oregon Mother's Care 2011**  
**North Central Public Health District (HD 33)**

<b>Table 1</b>			<b>Total # of OMC Clients by Month</b>	
	<b># Clients</b>		<b>% Clients</b>	
December 2010	3		7.10%	
January 2011	16		38.10%	
Februray 2011	13		31.00%	
March 2011	10		23.80%	
<b>Total Q1 2011</b>	<b>42</b>		<b>100%</b>	
April 2011	14		34.15%	
May 2011	15		36.59%	
June 2011	12		29.27%	
<b>Total Q2 2011</b>	<b>41</b>		<b>100%</b>	

<b>Table 2</b>					<b>OMC Site Clients by Insurance Status at Intake</b>			
	<b>Q1 2011</b>		<b>Q2 2 2011</b>					
	<b># Clients</b>	<b>% Clients</b>	<b># Clients</b>	<b>% Clients</b>				
CAWEM	2	4.8%	0	17.07%				
Oregon Health Plan	5	11.9%	7	12.20%				
Private Insurance	5	11.9%	5	68.29%				
None	30	71.4%	28	2.44%				
Unknown	0	0%	1	2.44%				
<b>Total</b>	<b>42</b>	<b>100%</b>	<b>41</b>	<b>100%</b>				

<b>Table 3</b>					<b>OMC Site Clients by Race &amp; Ethnicity</b>			
	<b>Q1 2011</b>		<b>Q2 2 2011</b>					
	<b># Clients</b>	<b>% Clients</b>	<b># Clients</b>	<b>% Clients</b>				
Causcasian	26	61.9%	25	60.98%				
Hispanic	11	26.2%	15	36.59%				
Unkown	5	11.9%	1	2.44%				
<b>Total</b>	<b>42</b>	<b>100%</b>	<b>41</b>	<b>100%</b>				

<b>Table 4 OMC Site Clients by Language</b>				
	<b>Q1 2011</b>		<b>Q2 2 2011</b>	
	<b># Clients</b>	<b>% Clients</b>	<b># Clients</b>	<b>% Clients</b>
English	35	83.3%	32	78.05%
Spanish	7	16.7%	9	21.95%
<b>Total</b>	<b>42</b>	<b>100%</b>	<b>41</b>	<b>100%</b>

<b>Table 5 OMC Site Clients by Age</b>				
	<b>Q1 2011</b>		<b>Q2 2 2011</b>	
	<b># Clients</b>	<b>% Clients</b>	<b># Clients</b>	<b>% Clients</b>
19 and Younger	11	26.0%	6	14.63%
20-24	11	26.0%	17	41.16%
25-29	14	33.0%	8	19.51%
30-34	2	5.0%	5	12.20%
35-39	4	10.0%	4	9.76%
40-44	0	0%	1	2.44%
<b>Total</b>	<b>42</b>	<b>100%</b>	<b>41</b>	<b>100%</b>

<b>Table 6 OMC Site Service Summary</b>				
	<b>Q1 2011</b>		<b>Q2 2 2011</b>	
	<b># Clients</b>	<b>% Clients</b>	<b># Clients</b>	<b>% Clients</b>
Pregnancy Testing	42	11.4%	38	10.4%
OHP Application Assistance	38	10.3%	39	10.6%
OHP Application Referral Only	4	1.1%	37	10.1%
OHP Application Faxed	21	5.7%	21	5.7%
Prenatal Care Provider Selected	37	10.0%	32	9.0%
Prenatal Care Appointment Scheduled by OMC Site	35	9.0%	29	8.0%
Initial Prenatal Needs Assessment	36	9.8%	29	7.9%
WIC Screening/Referral	42	11.0%	39	11.0%
MCM/Home Visiting Referral	40	11.0%	38	10.0%
Other Community Referrals	36	10.0%	32	9.0%
Attendance at First Prenatal Visit Confirmed	38	10.0%	33	9.0%
Dental Referral	0	0%	0	0%
<b>Total</b>	<b>369</b>	<b>100%</b>	<b>367</b>	<b>100%</b>

Table 7	Reason for Prenatal Appointment Dates Missing			
	Q1 2011		Q2 2011	
	# Clients	% Clients	# Clients	% Clients
Declined	0	0%	8	19.51%
TAB	2	4.8%	0	0
SAB	0	0%	1	2.44%
Will Make Own Appointments	1	2.4%	0	0
Unknown	39	92.9%	32	78.05%
<b>Total</b>	<b>42</b>	<b>100%</b>	<b>41</b>	<b>100</b>

Table 8	OHP Denials/Exceptions			
	Q1 2011		Q2 2011	
	# Clients	% Clients	# Clients	% Clients
Already has OHP Coverage	8	19.0%	7	17.07%
Expired/Lack of Info/No Client Response	2	4.8%	0	0%
Did Not Apply/Declined	0	0%	2	4.88%
Lost to Follow-Up	4	9.5%	4	9.76%
Moved Out of State	0	0%	1	2.44%
Over Income	1	2.4%	1	2.44%
SAB	1	2.4%	1	2.44%
TAB	1	2.4%	2	4.88%
Through DHS Office	6	14.3%	2	4.88%
Unknown	19	45.2%	21	51.22%
<b>Total</b>	<b>42</b>	<b>100%</b>	<b>41</b>	<b>100%</b>

Table 9	Trimester when Initial Contact was Made with OMC			
	Q1 2011		Q2 2011	
	# Clients	% Clients	# Clients	% Clients
First	36	85.7%	36	87.8%
Second	3	7.1%	5	12.2%
Third	3	7.1%	0	0
<b>Total</b>	<b>42</b>	<b>100%</b>	<b>41</b>	<b>100%</b>

Table 10	Trimester of Initial Prenatal Care (Before OMC Contact)			
	Q1 2011		Q2 2011	
	# Clients	% Clients	# Clients	% Clients
First	0	0	1	2.4%
Second	0	0	1	2.4%
Third	1	2.4%	0	0
Unknown	41	97.6%	39	95.1%
<b>Total</b>	<b>42</b>	<b>100%</b>	<b>41</b>	<b>100%</b>

Table 11	Trimester of First Prenatal Care (After OMC Contact)			
	Q1 2011		Q2 2 2011	
	# Clients	% Clients	# Clients	% Clients
First	33	78.6%	27	65.85%
Second	3	7.1%	4	9.76%
Third	2	4.8%	0	0
Unknown	4	9.5%	10	24.39%
<b>Total</b>	<b>42</b>	<b>100%</b>	<b>41</b>	<b>100%</b>

Table 12	Time Required for Late Trimester Clients to Enter Prenatal Care			
	Q1 2011		Q2 2 2011	
	# Clients	% Clients	# Clients	% Clients
Greater than 14 Days	0	0	1	2.44%
Less than or Equal to 14 Days	5	11.9%	3	7.32%
Unknown	37	88.1%	37	90.24%
<b>Total</b>	<b>42</b>	<b>100%</b>	<b>41</b>	<b>100%</b>

Table 13	Clients that Met Program Benchmarks			
	Q1 2011		Q2 2 2011	
	# Clients	% Clients	# Clients	% Clients
OMC Contact and Prenatal Care within First Trimester	33	79%	27	66%
Prenatal Care within 14 Days of OMC Contact for 2nd or 3rd Trimester	5	12%	3	7%
<b>Total</b>	<b>38</b>	<b>100%</b>	<b>30</b>	<b>100%</b>

### 3. Family Planning

NCPHD Family Planning Clinic continues to offer contraceptive and reproductive health counseling, initial and annual reproductive health exams, screening tests and/or treatment for STD's, and a wide variety of available birth control methods.

Our Nurse Practitioner resigned in September 2011. Our health officer, Dr Tracy Willett was hired as Family Planning Provider and sees clients in the clinic 2 ½ - 3days per week. The transition has gone well and Dr Willett's clinics are now full. Our Deputy Health Officer is available to provide STD Exam Clinic during Dr Willett's absence. In January, 2013, we hired Lisa Nevara, NP, to begin providing clinical services two days per week. Dr. Willett remains as Health Officer.

**NCPHD Current Family Planning Title X Data:**

<b>Women in Need (WIN), 2010</b>			
<i>County/Service Area</i>	<i>20-44 years</i>	<i>Teens 10-19</i>	<i>Total 10-14</i>
Oregon-ALL	184,615	58,649	243,264
Gilliam County	51	15	66
Sherman County	46	23	69
Wasco County	1,115	354	1,469
<b>Total 3 County's</b>	<b>1,212</b>	<b>392</b>	<b>1,604</b>

<b>Unduplicated Female Clients Served, FY 2011</b>			
<i>County/Service Area</i>	<i>20-44 years</i>	<i>Teens 10-19</i>	<i>Total 10-14</i>
Oregon-ALL	36,566	13,317	49,883
<b>Total Gilliam, Sherman and Wasco County</b>	<b>685</b>	<b>283</b>	<b>968</b>

<i>County/Service Area</i>	<i>Proportion of WIN Served</i>	<i>Pregnancies Averted, FY 2011</i>	<i>Teen Clients as % of Total Clients, FY 2011</i>	<i>Male Clients as % of Total Clients, FY, 2011</i>	<i>Proportion of Visits where Clients Rev'd Equally or More Effective Method, FY</i>
Oregon-ALL	20.5	10,048	26.0%	2.90%	90.5%
<b>Total Gilliam, Sherman &amp; Wasco County's</b>	<b>62.9</b>	<b>243</b>	<b>28.5%</b>	<b>1.10%</b>	<b>93.30%</b>

<b>Proportion of Visits at which Female Clients Received EC for Future Use, FY 2011</b>			
<i>County/Service Area</i>	<i>Teens (&lt;20)</i>	<i>Adults (20+)</i>	<i>Total</i>
Oregon-ALL	34.3%	22.0%	26.6%
<b>Total</b>			
<b>Gilliam, Sherman &amp; Wasco County's</b>	<b>41.2%</b>	<b>25.2%</b>	<b>30.4%</b>

<b>Teen Pregnancy Rate (per 1,000 Females Aged 10-17) CY 2009</b>	
<i>County/Service Area</i>	
Oregon-ALL	8.7
<b>Total</b>	
<b>Gilliam, Sherman &amp; Wasco County's</b>	<b>10.0</b>

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

*Goals-for Gilliam, Sherman and Wasco County's*

1. Improve and maintain the health status of women and men by providing reproductive health care services and to assure that all residents have access to effective family planning methods.
2. Assure continued high quality family planning and related preventative health services to improve overall individual and community health.
3. Reduce risk of unintended pregnancy.
4. Reduce teen pregnancy rates.

*Activities*

1. Ensure adequate follow-up for abnormal pap smears through pap tracking system.
2. Ensure adequate screening for Chlamydia following the screening guidelines from Region X Infertility Prevention Project.
3. Give women the widest possible choice of contraceptive methods from which to choose the method they are most likely to be able to use consistently and correctly over time.
4. Provide access to EC for current and future needs for all clients.
5. Evaluate texting of appointment reminders to clients and will evaluate for improvement in no show rate.
6. Continue to provide reproductive health exams, contraceptive counseling visits and education.

7. Maintain continuing education opportunities for all medical and support staff.

*Evaluation*

1. Review Ahler's data
2. Review Netsmart Insight data
3. Monthly chart audits

**4. WIC**

**FY 2012 - 2013 Oregon WIC Nutrition Education  
Plan Form**

**County/Agency:** North Central WIC

**Person Completing Form:** Lori Treichel, WIC coordinator

**Date:** 6-6-2012

**Phone Number:** 541-506-2627

**Email Address:** lorit@co.wasco.or.us

Return this form electronically (attached to email) to:

[sara.e.sloan@state.or.us](mailto:sara.e.sloan@state.or.us) by May 1, 2012

Sara Sloan, 971-  
673-0043

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

**Year 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, each agency's Training Supervisor(s) will complete the new eLearning Group Education Course.

Note: Target date for eLearning Group Education Course release is December 31, 2012.

**Implementation Plan and Timeline:**

**The North Central WIC training supervisor will complete the new e-learning group education course by March 31st, 2013.**

**Activity 2:** By June 30, 2013, WIC staff who lead group sessions and participated in the regional participant Centered Groups trainings in 2010-2012 will pass the posttest of the eLearning Group Education Course.

**Implementation Plan and Timeline:**

**WIC staff who lead group education classes and participated in 1 or more PCE trainings in 2010-2012 will pass the e-learning group education course post-test in the spring of 2013.**

**Activity 3:** By March 31, 2013, each agency will evaluate at least four nutrition education group sessions and a least one local agency staff in-service using the state provided group session evaluation tool. The tool will be distributed at the 2012 PC Groups Regional Training and available on the State WIC website.

**Implementation Plan and Timeline:**

**The state provided group session evaluation tool will be used by North Central WIC staff to evaluate 1 staff in-service and 4 Nutrition Education group sessions by March 15th, 2013.**

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

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

**Activity 1:** By March 31, 2013, each agency will evaluate at least one prenatal breastfeeding group session using the state provided group session evaluation tool. The tool will be distributed at the 2012 PC Groups Regional Trainings and available on the State WIC website.

**Implementation Plan and Timeline:**

**North Central WIC will complete an evaluation of 1 or more prenatal breastfeeding classes using the group session evaluation tool by March 31st, 2013**

**Goal 3: Strengthen partnerships with organization 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.

**Implementation Plan and Timeline:**

**Using the referral list in Twist, WIC staff will identify 1 unfamiliar referring organization and learn more about the services they provide to WIC participants by September 30, 2012. This organization will be invited to speak at an “all staff” meeting to inform NCPHD of the services they provide by March 31, 2013.**

**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 meet and discuss how they can partner together to enhance breastfeeding support in their community.

**Implementation Plan and Timeline:**

**In September 2012 staff will use TWIST to identify one organization they would like to work with to strengthen breastfeeding referrals. By March 31st WIC staff will invite a representative of said organization to meet and discuss partnering to enhance breastfeeding support services in our community.**

**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 is communicating health outcomes to participants during certification visits.

**Implementation Plan and Timeline:**

**North Central WIC staff will increase their understanding of at least 2 factors that influence health outcomes by January 31, 2013. The staff will then develop and implement a plan to provide quality nutrition education and feedback on their family members health outcomes at certification appointments by March 31st, 2013.**

**Activity 2:** Identify your agency training supervisor(s) and projected staff quarterly in-service training dates and topics for FY 2012-2013. Complete and return Attachment A by May 1, 2012.

**Lori Treichel, RN,  
BSN, MS WIC  
Coordinator**

## 5. Immunization

Local Public Health Authority Immunization Annual Plan Checklist  
July 2012-June 2013  
North Central Public Health District County Health Department

LHD staff completing this checklist: Dianne Kerr

### 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) Work with and engage all vaccine preventable disease providers to participate in an immunization coalition. Members of the coalition would represent all three counties (Wasco, Sherman and Gilliam) within the health district. Participation can be both by phone or by attending the meetings.

(Activity 2) Attend a Probation and Parole Staff meeting to educate case workers about Hepatitis A & B Vaccine, which is offered at the health department to their clients at no charge. Provide case workers with a pamphlet to give to clients with information regarding available vaccines and health department hours of operation.

**Surveillance of Vaccine-Preventable Diseases**

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

**Adverse Events Following Immunizations**

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

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

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

**School/Facility Immunization Law**

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

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

b. Issues exclusion orders as necessary

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

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

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

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

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

Report submitted?  Yes  No

**Performance Measures**

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

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

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

**Reporting Obligations & Periodic Reporting**

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

## 6. Environmental Health

### Current Condition or Problem

1. The function of North Central Public Health District Environmental Health Program is to identify health risks in the environment and implement or promote solutions that eliminate or reduce risk. This includes investigation and containing diseases and injuries to reduce the incidence of contagious diseases, and reduce the disabilities related to disease and injury.
2. The Environmental Health (EH) program covers three counties: Wasco, Sherman and Gilliam.
3. The EH program currently contains 3.0 FTE Environmental Health Specialists (EHS); and is fully staffed as of 6-8-10.
4. The Environmental Health services offered include, but are not limited to:
  - a. Sanitation inspections
  - b. Plan reviews
  - c. Licensing
  - d. Enforcement
  - e. Complaint investigation
  - f. Technical assistance and formal training of restaurants, public swimming pools and spas, motels, organizational camps and RV parks
  - g. State (DHS) Drinking Water Program
  - h. Department of Environmental Quality (DEQ) Onsite Wastewater Management Program

Additionally, Wasco County Environmental Health is the lead agency for the Tri County Hazardous Waste Management and Recycling Programs serving Wasco, Sherman and Hood River Counties. These programs contain 1 FTE Hazardous Waste and Recycling Coordinator and 1.5 FTE Solid Waste Specialist.

## **Goals**

1. Field train the 3<sup>rd</sup> FTE EHS in the Onsite Wastewater Management Program (OWM) and with our fully staffed EH program be prepared to assume the OWM Program in Gilliam County if it becomes necessary.
2. To increase the percentage of restaurant managers with advanced Special Food Manager Training within North Central Public Health District.
3. To continue having a State Standardized Food Program Training Officer.
4. To conduct sanitation inspections of licensed facilities in a timely manner.
  5. To continue coordinating food & water borne investigations and vector diseases within the Communicable Disease (CD) team.
  6. To continue Food Handler training.

## **Activities**

1. Conduct health inspections of all licensed facilities.
2. Conduct health inspections of unlicensed facilities as requested (prison, certified day care facilities, school food service programs, nursing homes, etc.).
3. Provide Environmental Health education to the public.
4. Collect data on licensed facilities, water systems and waste management.

## **Evaluation**

1. Files will be maintained for each licensed facility and contain inspection reports.
2. Logs of citizen complaints will be kept regarding licensed facilities.
3. Logs of all animal bites are kept. Information will be provided to the state.
4. Food Handler testing records will be kept.

## **Drinking Water Program**

Currently, all systems are either up to date on Sanitary Surveys or have scheduled appointments for surveys.

The current billing system is largely based on fees for services ensuring compliance with current standards and violation corrections. As water systems have received more guidance and recommended improvements are made, it becomes difficult to reach full billing potential. Recently “State” water systems were deleted from oversight by DHS. Most of these water systems have had limited contact with county staff. The reduction of billing potential for “State” water systems was offset by changes to the Inter Governmental Agreement fee formula dealing with deficiency corrections.

## **Food Borne Illness & Fecal Oral Illness**

Food borne disease investigation is conducted with a team approach, involving Environmental Health (EH) and the Communicable Disease (CD) team. Fecal-oral illness whether food, water or physical cross contamination is also investigated using a team approach. Either of the above events may activate a Crisis Action Center within the Health Department.

## **7. Health Statistics**

There are no substantial changes in the area of Health Statistics. Gilliam County births and deaths continued to be registered by the Gilliam County Clerk’s office.

## **8. Information and Referral**

There are no substantial changes in the area of Information and Referral.

## **9. Public Health Emergency Preparedness**

The PHEP Program serving Wasco, Sherman and Gilliam Continues to be coordinated by Kristy Beachamp and she works closely with the emergency managers for each of the three counties. Outreach activities have included the partnership with Wasco County Emergency

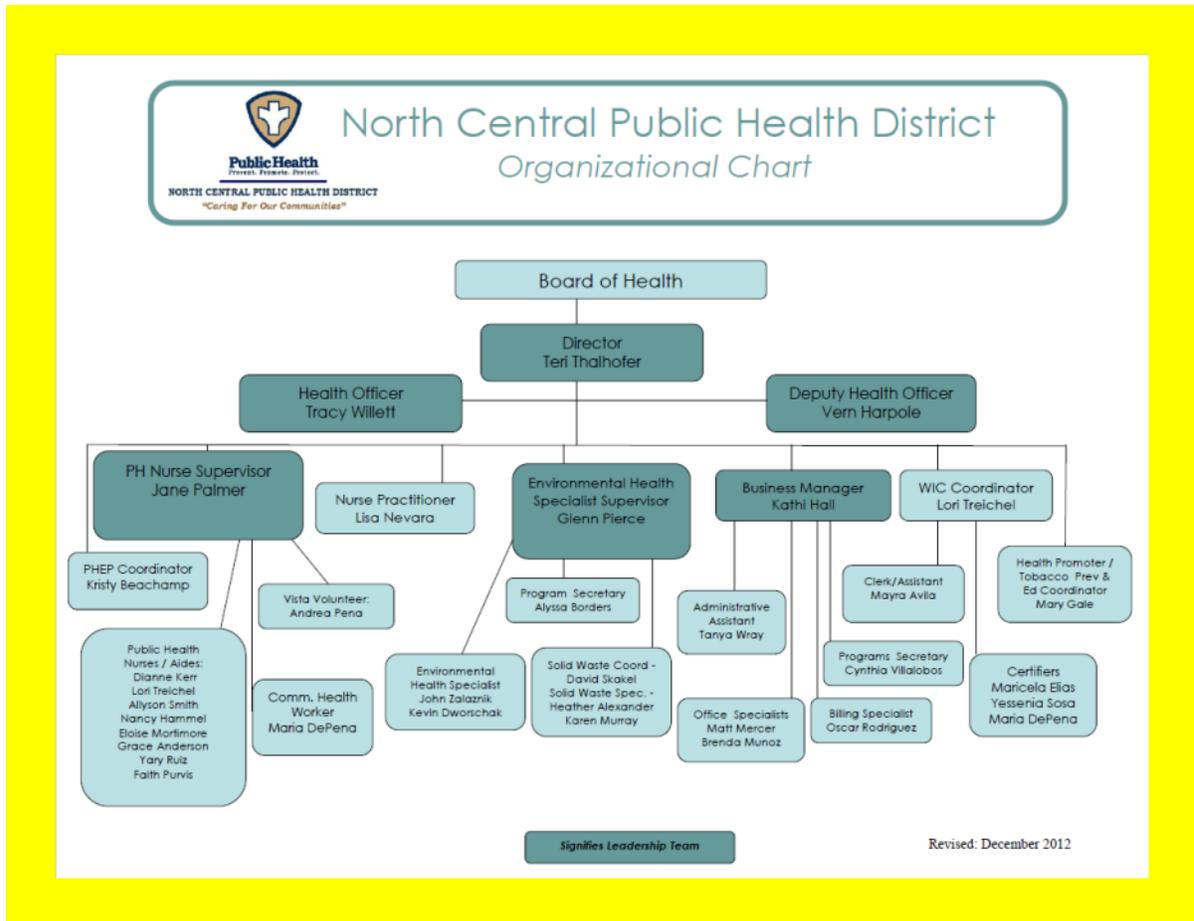
Management and the Red Flag Task Force to present the annual Emergency Preparedness Fair for the local community. This task force is a diverse group of Wasco County public and private agencies committed to providing emergency preparedness information and resources to the community.

Kristy was the lead for PPHR. NCPHD completed the PPHR application criteria were submitted in September 2011. Results are not available as this time.

Project Public Health Ready (PPHR) is a competency-based training and recognition program that assesses preparedness and assists local health departments, or groups of local health departments working collaboratively as a region, to respond to emergencies. It builds preparedness capacity and capability through a continuous quality improvement model. The PPHR criteria are the only known national standards for local public health preparedness and are updated annually to incorporate the most recent federal initiatives. Each of the three PPHR project goals—all-hazards preparedness planning, workforce capacity development, and demonstration of readiness through exercises or real events—has a comprehensive list of standards that must be met in order to achieve PPHR recognition

## IV. Additional Requirements

### 1. NCPHD Organizational Chart



## **2. Board of Health**

On October 7, 2009, an Intergovernmental Agreement became effective for North Central Public Health District. This agreement followed the resolutions under ORS 431.375(2) which formed the District earlier in the year. On January 25, 2010, bylaws were adopted creating a board of health comprised of one member of each of the three county commissions and 2 public members from each of the three counties. The public members are specifically designated as a city or town administrator, a school district representative, a physician or other health professional, a social services representative, and business representative and a private citizen. The Board meets usually monthly but must meet at least quarterly. These meetings are publicly noticed in each of the three counties. Phone conferencing is available. The Public Health Administrator reports to the board of health.

## **3. Health Advisory Board**

A public health advisory board does not currently exist.

## **4. Triennial review noncompliance findings**

N/A

## **5. Coordination of Services**

No significant changes have occurred in the NCPHD relationship with either the Wasco or Sherman County Commissions on Children and Families. In Gilliam County, Dianne Kerr, RN, attends Commission meetings and works with staff and community members on current issues. The TPEP Coordinator for NCPHD also participates in prevention activities in Gilliam County. Teri Thalhofer, RN, serves as the Co-Chair of the Early Childhood Committee of the WCCCF.

## **V. Unmet Needs**

Access to primary care remains an issue for uninsured residents of the NCPHD. The FQHC serving Wasco and Hood River Counties faces issues of provider retention. We at NCPHD have worked closely with the new Medical Director and Executive Director as they work to implement strategies to stabilize staffing.

Access to dental care is an issue for the uninsured as well as for those clients served by the Oregon Health Plan. NCPHD school nurses provide fluoride programming to rural schools, and staff works with other local programs to increase access to services such as the “Tooth Taxi” and fluoride varnishing programs when opportunities arise.

We are hopeful that health care reform on the national and state level may help increase capacity for such services. We will continue to support local efforts as opportunities arise.

## **VI. Budget**

The LPHA's public health budget resides in the Wasco County budget at:

*[http://co.wasco.or.us/county/dept\\_treasurer\\_finance.cfm](http://co.wasco.or.us/county/dept_treasurer_finance.cfm)*

## VII. Minimum Standards

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

### Organization

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

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

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

### **Control of Communicable Diseases**

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

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

### **Environmental Health**

47. Yes  No \_\_\_ Food service facilities are licensed and inspected as required by Chapter 333 Division 12.
48. Yes  No \_\_\_ Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.
49. Yes  No \_\_\_ Training in first aid for choking is available for food service workers.
50. Yes  No \_\_\_ Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided.
51. Yes  No \_\_\_ Each drinking water system conducts water quality monitoring and maintains testing frequencies based on the size and classification of system.
52. Yes  No \_\_\_ Each drinking water system is monitored for compliance with applicable standards based on system size, type, and epidemiological risk.

53. Yes  No  Compliance assistance is provided to public water systems that violate requirements.
54. Yes  No  All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken.
55. Yes  No  A written plan exists for responding to emergencies involving public water systems.
56. Yes  No  Information for developing a safe water supply is available to people using on-site individual wells and springs.
57. Yes  No  A program exists to monitor, issue permits, and inspect on-site sewage disposal systems.
58. Yes  No  Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.
59. Yes  No  School and public facilities food service operations are inspected for health and safety risks.
60. Yes  No  Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12.
61. Yes  No  A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste.
62. Yes  No  Indoor clean air complaints in licensed facilities are investigated.
63. Yes  No  Environmental contamination potentially impacting public health or the environment is investigated.
64. Yes  No  The health and safety of the public is being protected through hazardous incidence investigation and response.
65. Yes  No  Emergency environmental health and sanitation are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control.
66. Yes  No  All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448.

## **Health Education and Health Promotion**

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

## **Nutrition**

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

## **Older Adult Health**

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

## **Parent and Child Health**

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

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

### **Primary Health Care**

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

### **Cultural Competency**

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

## Health Department Personnel Qualifications

### Local health department Health Administrator minimum qualifications:

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

Answer the following questions:

Administrator name: Teri Thalhofer

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

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

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

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

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

AND

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

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

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

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

OR

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

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

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

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

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

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

*Teri Thalhofer*, Director  
Local Public Health Authority

NCPHD  
County

11/22/11  
Date

## Appendix E

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

July 1, 2012 to June 30, 2013

**Agency: North Central Public Health District**  
**Contact: Mary Catherine Clites, Family Planning Coordinator**

**Goal # 1** Move forward with adapting family planning and reproductive health services to the requirements of state and national health care reform, including the use of electronic health records, partnering with Coordinated Care Organizations (CCOs), investigating participation in health insurance exchanges, etc.

Problem Statement	Objective(s)	Planned Activities	Evaluation
NCPHD currently is not using EMR and CCO's guidelines have not been established	Implement EMR	<p>Netsmart from Insight EMR has been purchased.</p> <p>Build Insight tables meeting Title X requirements.</p> <p>Super User Training group will be trained</p> <p>EMR will be implemented</p>	<p>Netsmart has been purchased with STD, FP, Immunization, Registration, Administration, Billing.</p> <p>Building of Insight tables will be completed by November 23, 2010.</p> <p>Super User Training is scheduled for Nov 28-Dec 2, 2011. Super users are: Kathi Hall Finance/Office Manager, Oscar Rodriguez Billing Specialist, Mary Cath Clites Clinical Program/Nursing Supervisor/FP Coordinator, Grace Anderson Public Health Nurse and Maria Pena Community Health Worker.</p> <p>Go live date for EMR services is scheduled 1/3/2012.</p>

	<p>Partner with CCO's to provide family planning services</p>	<p>Evaluate CCO requirements when they are released.</p> <p>Work with community partners to ensure services will be met.</p> <p>Partner in the development of CCO's in the community ensure Family Planning needs are met in the community.</p> <p>Monitor financial status of Family Planning clinic and effects of CCO's/HCR.</p>	<p>CCO program requirements will be established by 12/2012.</p> <p>NCPHD will be at the table during discussions of CCO's in the community (1<sup>st</sup> meeting 10/2011).</p> <p>Ensure Family Planning needs for clients are met during the development and implementation of CCO's.</p> <p>Continue quarterly and FY end revenue reports.</p>
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**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.

<b>Problem Statement</b>	<b>Objective(s)</b>	<b>Planned Activities</b>	<b>Evaluation</b>
<p>Family Planning presents challenges for health financing mechanisms to maintain a broad range of birth control methods.</p>	<p>Maintain current available methods of birth control.</p> <p>Assess financial status of the program and continue quarterly revenue monitoring.</p>	<p>Give women the widest possible choice of contraceptive methods from which to choose the method they are most likely to be able to use consistently and correctly over time.</p> <p>Provide access to EC for current and future needs for all clients.</p> <p>Provide all components of providing the method, including the drug or device itself and any clinical services that are necessary, such as the insertions of an IUD/Implanon or the injection of Depo-Provera.</p> <p>Update pricing of birth control methods quarterly.</p>	<p>Enable women to avoid pregnancy when they do not want to be pregnant, plan for pregnancy when they do. Measured by # of women in need of publicly funded contraceptive services and supplies/percentage of women in need served, which should lead to decrease in teen pregnancy rates. Measured on an annual basis comparing to previous years data.</p> <p>Continue quarterly and FY end revenue reports.</p> <p>Continue quarterly and FY end tracking of clients served.</p> <p>Completion of pricing changes and implementation of new prices quarterly.</p>

Objectives checklist:

- Does the objective relate to the goal and needs assessment findings?
- Is the objective clear in terms of what, how, when and where the situation will be changed?
- Are the targets measurable?

- Is the objective feasible within the stated time frame and appropriately limited in scope?

**Progress on Goals / Activities for FY 2012**  
(Currently in Progress)

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

Goal / Objective	Progress on Activities
<p>Goal: Assure continued high quality clinical family planning and related preventive health services to improve overall individual and community health.</p> <p>Objectives: Assess financial status of the program and perform a cost analysis on a regular basis.</p> <p>Hire a Billing Specialist in place of the Office Specialist currently performing the role of fee collection. This will provide the opportunity to bill accurately and increase revenue potential.</p> <p>Increase number of clients served by at least 10% by the period ending June 30, 2011.</p>	<p>In 7/2011 a cost analysis was completed and fees were adjusted.</p> <p>A NCPHD Office Specialist was hired as a Billing Specialist and has ensured billing services are now being performed accurately. The Billing Specialist also monitors/tracks billing for BCCP.</p> <p>Family Planning clients served in 2008 were 1,029 and in 2010 1,138. Unduplicated female clients served as of now for FY 2011 total is 968.</p>

<p>Increase the numbers of teens served in clinic by at least 10% by the period ending June 30, 2010.</p>	<p>The number of teens served in 2008 was 300 and 2010 there was an increase to 319 served. Unduplicated female teens served as of now for FY 2011 is 283.</p>
<p>Goal: Assure ongoing access to a broad range of effective family planning methods and related preventive health services.</p> <p>Objectives: Nursing staff will be trained to perform STD exams for male and female clients by June 30, 2008.</p> <p>Provide system structure that allows RN to perform limited STD exams.</p> <p>Develop a system for cross coverage for nurse practitioner leave time by June 30, 2011.</p>	<p>Currently trained Nursing staff (RN's) are not providing STD exams for male and female clients due to concerns if this was in their scope of practice. NCPHD is waiting for Policy development before resuming RN STD exam services. Currently all STD exams male and female are provided by on staff Family Planning MD.</p> <p>Our Nurse Practitioner resigned in September 2011. Our health officer, Dr Tracy Willett was hired as Family Planning Provider and sees clients in the clinic 2 ½ - 3days per week. The transition has gone well and Dr Willett's clinics are now full. Our Deputy Health Officer is available to provide STD Exam Clinic during Dr Willett's absence.</p>