

# **Coos County Public Health**

## **Comprehensive Plan**

**2007-2008**

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## **Executive Summary**

Coos County Public Health continues to provide a range of services to meet health needs of the community. We expect to have a reduction in the level of services (or number of clients served) due to the loss of revenue from federal timber payments. Further reductions in services are possible, depending on whether other projected revenue is received. With a projected budget of \$2.8 million for FY 2007/2008, we expect to employ 30 staff who implement our programs through the following subdivisions of the department: Family Health Field Services, Environmental Health, Prevention Services, Clinic Services, Women, Infants and Children's Nutrition Program, and Administration and Support Services.

Our Department provides the 5 essential services required by Oregon law. Through these mandated services, we are addressing important social and health problems: teen pregnancy prevention, child abuse prevention, adequate prenatal care, protection from communicable diseases, and assurance of safe food and drinking water for the public. We also record vital statistics and provide health information and referral services.

Most of our programs follow the funding streams that come to us through Oregon's Department of Human Services--State Public Health. Most of these funds have remained static over the years, or have decreased, while our costs have gone up. State support for public health, which is awarded to our county on a per capita basis at 59 cents per person per year, is not even sufficient to fund one nurse. The federal funds for public health preparedness, which help our department to respond to communicable disease outbreaks as well as support critical emergency response planning have also been reduced, except for the special federal award directed towards pandemic flu preparedness.

We continue to have concerns about the high rate of sexually transmitted diseases in young people (and the limited funding for HIV prevention); the emergence of active TB in our community; the high level of obesity, and the number of citizens who are uninsured for medical care. Health indicators for Coos County continue to reveal high rates of substance abuse and child abuse--problems that are correlated with the chronic unemployment and poverty in our area. We have one of the highest rates of adult smoking in the state, which contributes to our leading cause of death--cardiovascular disease--and to our county's ranking as number one in the state for the lung cancer death rate. Chronic diseases such as arthritis and diabetes (again, some of the highest rates in the state) affect the quality of life of our aging population.

We are one of the counties receiving funds for a tobacco prevention project. We have been unable to obtain competitive funding to continue our diabetes and asthma projects, and have had to terminate our Prevention Services Manager due to lack of funding. In our family health field services programs, we are making a difference, with more pregnant women receiving early prenatal care, and an increase in our clients' parenting skills and the corresponding reduction in child abuse. This Annual Plan document includes action plans addressing important public health issues. These plans guide the work of our dedicated staff, who continue to meet the challenge of providing a wide range of services, with limited funding, in a community with many needs.

## Public Health Indicators in Coos County

The **64,711 persons living in Coos County** on the southern Oregon coast have a **median age of 43.1 years**. Residents in this mostly rural county live as part of one of seven communities spread out over 1629 square miles. They are:

- ◆ **93.6%** white, or **90.1%** white non-Hispanic,
- ◆ **4.1%** Latinos (Hispanics),
- ◆ **2.3%** Native Americans,
- ◆ **1%** Asians,
- ◆ **0.4%** Black or African Americans, and
- ◆ **0.2%** Hawaiian/Pacific Islanders.

The largest population centers are the adjacent communities of Coos Bay (15,823) and North Bend (9544), which border the largest deep-water port on the Oregon coast. The rich ocean and lush forests once supported thriving commercial fishing and timber harvesting industries whose importance to the economy has declined. Seasonal jobs dependent on tourism have replaced many family wage jobs.

- ◆ The per capita income is **\$25,784** (state: \$32,174), with a median household income of **\$31,945** (state: \$43,262).
- ◆ **15%** of the population lives below the poverty line (state: 12%).
- ◆ As of December 2006, **6.4%** of adults in Coos County were unemployed. The rate for the year of 2005 was **7.3%**.
- ◆ In 2005, **13.8%** of the population were enrolled in the Oregon Health Plan.
- ◆ On the Oregon Healthy Teens survey for 2005-2006, **21%** of eleventh graders reported physical health care needs that had not been met in the previous 12 months, because of financial restraints. The 2000 census showed that **14.6%** of the population of Coos County had no health insurance compared to 13.5% in Oregon, and **12%** of children under age 18 in the county had no health insurance compared to 11% statewide.

Public Health concerns in Coos County have multiple causes and are related in part to poverty, socioeconomic conditions, our aging population, the environment, and behavioral factors. Some major issues are:

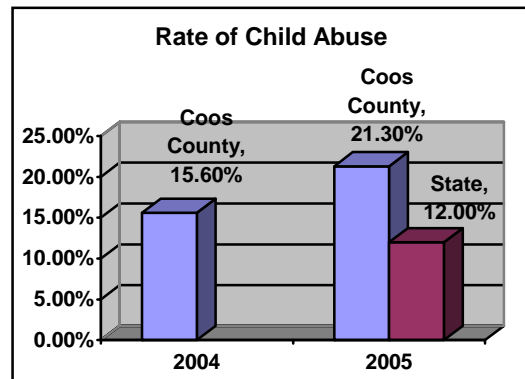
**Alcohol and Drug Use:** On the 2005-2006 Oregon Healthy Teens survey (OHT), **35%** of 8<sup>th</sup> graders and **42.6%** of 11<sup>th</sup> graders reported having consumed beer wine or hard liquor in the previous 30 days. Amongst 11<sup>th</sup> graders, **26.3%** reported having 5 or more drinks in a short period of time during the last 30 days. On the OHT survey, **17.7%** of eighth graders and **26.4%** of 11<sup>th</sup> graders reported use of illicit drugs during the past 30 days.

**Cancer:** Figures for 1999-2003 show an age adjusted cancer rate 3.3 percentage points lower than the previous years' report. **This puts Coos County third in the state (out of 36 counties) for high incidence cancers.** Much of this is a consequence of historically high smoking rates.

Rates for high incidence cancers were **542.1** per 100,000 compared to 484.0 for the state. Coos County:

- ◆ Achieved age adjusted cancer mortality rates of **228.7** (state: 198.9).
- ◆ Ranked **highest** in the state for incidence of lung cancer at **93.8** per 100,000 (state:70) and **highest** for lung cancer deaths at **78.8** per 100,000 (state:56.4).
- ◆ Ranked **third** in the state for age adjusted rate of malignant melanoma with a rate of **29.5** per 100,000,
- ◆ Ranked **4<sup>th</sup>** for oral and pharyngeal cancer with a rate of **14.6** per 100,000 (state: 11.3).
- ◆ Had rates of breast cancer, at **142.9**, similar to the state levels of 142.7.
- ◆ Ranked **7<sup>th</sup>** at **46.4** (state: 49.8) for colon and rectal cancers
- ◆ Had incidence rates of **169.7** (state: 164.0) for prostate cancer, with age adjusted mortality of **27.2** (state: 29.8).

**Child Abuse:** Coos County ranked **7<sup>th</sup>** in the state with a rate of **21.3%** in 2005, up from 15.6% in 2004. The state rate is 12%. In 2005, there were 781 reports of child abuse and neglect and 154 foster care entrants. The high rate of child abuse and neglect is usually attributed to the high rates of several stress factors, including drug and alcohol abuse, crime, domestic violence and unemployment. Mothers were involved in the abuse/neglect **45.7%** of the time, fathers **29.1%** of the time and stepfathers **4.5%** of the time. The major reasons for placement in foster care were drug and alcohol abuse, physical abuse, neglect, the child's behavior, inability to cope, and inadequate housing.



**Chronic Disease:** Asthma continues to present a health burden to residents of Coos County with a population prevalence of **8.7%** as measured by a combined 2002-2005 survey. This means some **5400 people in Coos County suffer from asthma**. The asthma rate for the Medicaid population is more than double that of privately insured persons.

According to the 2004 Behavioral Risk Factor Surveillance System survey, **27%** of adult Oregonians suffered from diagnosed arthritis and another **22%** had chronic joint symptoms that were not formally diagnosed as arthritis. The state rate of arthritis in 2000 was 35%. Coos County's rate was **48%**. Arthritis is the leading cause of disability in the U.S.

The death rate from diabetes in Coos County is 1.7 times the diabetes death rate in the state. Diabetes provides a significant contribution to poor health in Coos County. The diabetes rate is **8.3%**, quite a bit higher than the state rate of 5.5%. It is estimated that **2.4%** of the residents have undiagnosed diabetes. **This means that currently well over 10.7%, or 6700, of the people in Coos County have diabetes**. This number is expected to grow markedly as a result of our high rates of smoking and overweight.

In Coos County **5%** of the population has suffered from heart attack, **7%** from coronary heart disease, and **3%** from stroke. Statewide, the prevalence rate for heart attack is about 4%, the rate for coronary heart disease is about 4% and the rate of stroke is 2.5%. In 2002 heart disease and stroke combined accounted for 35% of the total deaths, and heart disease was the number one cause of death in 2004. In 2000 Coos County was 7<sup>th</sup> in the state for death from heart disease at 332.9 per 100,000 compared to the state level of 207.6.

**Communicable Disease:** Chlamydia remains the most common reportable communicable disease in Coos County with **115** cases reported in 2005. There were **2** cases of gonorrhea, and no new cases of syphilis. Other diseases include: **5** cases of pertussis; **3** cases of meningococcal disease; and **2** active cases of tuberculosis.

#### **Environmental Health Issues:**

- ◆ Alerts were issued on **6** separate occasions for bacteria counts exceeding the maximum contaminant level in public water systems.
- ◆ **2** boil water notices for community water systems were issued.
- ◆ A harmful algae bloom closed recreational shellfish harvesting on the Coos County Coast for several weeks.
- ◆ **10** health advisories (ranging from 2-8 weeks) discouraged water contact on two ocean beaches as a result of Enterococcus bacteria levels.
- ◆ **4** municipal sewage treatment systems reported outflows of untreated sewage into fresh water.
- ◆ **6** properties remain catalogued on the “unfit for use list” due to methamphetamine drug lab contamination.

**Hunger:** Hunger is most often a direct consequence of poverty. The Coos County poverty rate was **16%** in 2004 compared to a state rate of 13%. Coos County had the fourth highest poverty rate in the state. Over 20% of children in the county live in poverty. Families with poverty level incomes in Coos County can only afford about half of a basic family budget. In the county, **15.5%** of the population receives Food Stamps and **51.6%** of school children qualify for Free and Reduced Lunch Programs. Single parent families make up about **10%** of the population. Single mothers have a **38.7%** poverty rate. Eleven percent of eighth graders report that they or their family members skip meals or eat less because of financial restraints.

**Overweight and Obese:** Obesity has become the second most important preventable cause of disease, disability and death. In Coos County the latest reported figures show a **41%** rate of overweight and a **23%** rate of obesity compared to 37% and 20% respectively for the state.

**Tobacco Use:** Coos County is tied for fourth place for smoking rates, with **27%** of the adult population being smokers. Statewide, the rate is under 20%. The smoking rate in Medicaid clients in Coos County is 39%. In Coos County, 23% of pregnant women smoke, compared to the state smoking-in-pregnancy rate of just over 11%. On the OHT survey, 15.9% of eighth graders report living in a house where someone smokes inside the house. Smoking in young people continues to be relatively low, with only 4.2% of eighth graders and 9.6% of 11<sup>th</sup> graders

reporting smoking on 10 or more days in the last month. Almost 70% of eighth graders have never smoked a cigarette. Almost **25%** of all deaths in the county are smoking related.

**Some Public Health successes are:**

- ◆ Teen pregnancy rates (age 10-17) declined over 5 years from 10.2 per 1000 in 2002 to 7.8 in 2003 and continued to decline to 7.3 in 2004. However, the preliminary rate for Coos County from October of 2004 to September of 2005 is **9.1**. This still compares favorably to the 2004 state rate of 9.5.
- ◆ The rate of low birth rate babies continues to improve, decreasing to 6.0% (38 babies) in 2004 from 7.3% in 2003. The state rate for 2004 was **6.1%**. The 2004 U.S. rate was 3.6%
- ◆ The rate of mothers who receive late or no prenatal care continued to decline in 2004 to **4.0%** (state: 4.1%). This is an improvement over 2003, when the county rate was 6.2%.

## **ADEQUACY OF the 5 BASIC SERVICES (Required by ORS 431.416)**

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

Public Health staff (public health nurses, environmental health specialists, and the health officer) follow up on any confirmed or suspected cases of 42 diseases and 9 other conditions for which medical providers and labs in Coos County are required by law to report to the health department. We coordinate these reports with state public health. We work to identify the cause or source of any outbreak, identify those who have been exposed to communicable disease, provide health guidance and preventive measures, when appropriate and available (e.g., vaccines and medications) and work to prevent the spread or recurrence of disease. Our health department also reports any clients that we have diagnosed in our clinic. Staff in this program provide consultation to health providers in the community and education to the general public on communicable diseases.

Funding is insufficient to have staff dedicated solely to investigation of communicable disease reports. Completion of investigations by Fridays, especially when the case is reported at the end of the week, is an ongoing challenge. Nurses continue to respond to the CD pager calls on a 24/7 basis. A large outbreak or public health emergency would require far greater resources than this department has available.

Our department has lost funding that we have had in past years to provide prevention programs for the chronic diseases of diabetes and asthma. We are no longer administering the breast and cervical cancer screening program, although we hope to because a service provider, when the state issues us a contract. We are pleased to have funding for a tobacco prevention program, as our rates of smoking continue to be higher than the state rates.

### **2. Parent and child health services, including family planning clinics (ORS 435.205)**

Nurses provide home visitation in Babies First!, Parents as Teachers, CaCoon, and Healthy Beginnings (the maternity case management program). Parent educators, both nurses and public health aides, who are supervised by a nurse, use the Parents As Teachers curriculum, and nurses augment their visits with the Babies First! protocols. We have a limited staff in CaCoon, and we try to stretch our resources to serve the children with special health care needs. Our department is also now providing the Healthy Start program in our county, with two public health aides supervised by a nurse.

For this coming year, we are projecting to have 3.4 FTE nurses in the home visiting programs. Additional nurse time is projected to be contracted at 1.6 FTE. One full time nurse will work with Coos County Mental Health providing infant and family mental health counseling, and .6 FTE will work with DHS's Self sufficiency JOBS Program to help case managers with health assessments. Of the 3.4 FTE of nurses who will provide home visiting services, 1.5 FTE are projected to provide maternity case management. Due to the low Medicaid reimbursement rates, we are concerned about the ability to sustain this level of service. Staff also include 3 paraprofessional parent educators, including 2 who work in Healthy Start.

All Parent Educators provide parent education, advocacy, and support to parents. In addition, we focus on prevention of family violence, prevention of, or intervention for substance abuse, SIDS risk reduction, child nutrition, immunizations, child safety, developmental screening, and case

management. All home visitors in the Healthy Beginnings program are supervised by an experienced Public Health Nurse with a Masters in Public Health. All of our home visiting programs work to prevent child maltreatment through the provision of services that strengthen families. Our home visiting programs are highly accessible as we provide services throughout Coos County. Our programs are in demand, and we usually have clients on a waiting list.

According to the service data for Oregon Title X Family Planning Agencies, there are 3,032 *women in need* (WIN) in our county between the ages of 13 and 44. We served 1,686 of those WIN clients in 2005, or 56%, (compared to 59% the previous year) *State average 2005: 33.1%*. Of the estimated number of teens in need of services (n=772) we served 74% (n=570). Our contraceptive services are estimated to have averted 323 pregnancies. The teen pregnancy rate in the county continues to decline and has been below the state average, although preliminary data for 2005 show an increase in the teen pregnancy rate.

After years of planning, this past year we received funding for a certified school based health center, located on the Marshfield High School Campus. The SBHC is operated through a contract with Waterfall Clinic.

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

We register all births and deaths in Coos County and forward the information to the state, as required by administrative rules. In addition to the County Registrar, our lead deputy registrar, who is available full time, has backup support from 3 other individuals who serve as deputy registrars.

### **4. Health Information and Referral Services.**

All health department programs provide health information and referrals to programs within our agency and also to outside agencies that can help meet needs that are beyond the scope of our agency. Examples include referring a person with AIDS for housing, referring a pregnant woman to a medical doctor for prenatal care, referring a young parent for food stamps. Our support staff who answer the main switchboard spend significant time as a referral source. We strive to keep up-to-date on our community resources and our referral lists current. Health education, with a prevention focus, is also a key component of our public health programs.

To enlighten the community about public health services, we continue to publish an annual report, post messages on our electronic sign on the front of the County Annex, and strive to complete our website.

### **5. Environmental Health Services**

The Environmental Health program licenses and inspects restaurants, motels, RV parks, pools, spas, and organizational camps. Our environmental health specialists teach and certify food handlers and also provide food service manager training. To protect from food-borne illnesses, we license and inspect temporary food events that are open to the public. We also investigate reported cases of food-borne and water-borne illnesses. We monitor small public water systems and perform a limited number of septic loan inspections. We also inspect correction facilities, school kitchens, and daycare centers.

For the on-site sewage disposal system within Coos County, the Oregon Department of Environmental Quality (DEQ) maintains all regulatory oversight. Our department may consider delegation for this function at a future date.

Solid waste is not regulated by this department. Individual cities have independent solid waste ordinances, as does Coos County. Our staff frequently receive nuisance complaints related to illegal dumping and make referrals to the applicable jurisdiction for code enforcement. Privately operated Sanitation/Garbage companies handle the majority of domestic solid waste within Coos County. Beaver Hill Disposal Site is the only solid waste disposal site within the county and is operated by Coos County. Regulatory oversight is provided by the DEQ.

Staff consist of a full time Environmental Health (EH) Specialist trainee and an EH Program Manager, with .5 FTE clerical support.

The following describes the **adequacy of services the Health Department should include or provide for in programs, according to OAR 333-014-0054.**

### **1. Dental.**

The water system serving our largest populated area has fluoridated water. Many others in our rural county are on small water systems without fluoridation or have private wells. Dental awareness is conducted through WIC and home visiting programs, and nurses conduct visual "lift the lip" exams with children 0-5 during home visits. Care for children's teeth is discussed, and brochures on baby bottle tooth decay and toothbrushes are distributed. The maternal / child health staff are continuing to work with local dentists and community partners to increase access to dental care for pregnant women and children.

### **2. Emergency Preparedness.**

Our department's role in a declared emergency is to coordinate the health system response throughout the county. In response to a bioterrorist event or other public health emergency, we would also work to protect the public's health by preventing additional exposure to communicable agents and provide counter measures, such as vaccine and antibiotics. Staff have worked with the County Emergency Management staff to update the medical portion of the County's Emergency Response Plan and have drafted the emergency communication plan for the department and the pandemic influenza response plan. We meet monthly with community partners to work on health system issues in emergency response.

### **3. Health Education and Health Promotion.**

Health education and promotion are components in all Health Department programs. Examples that we will continue to provide include breastfeeding support in WIC; food handler training; parent education for parents of newborns; correct use of child safety seats in vehicles; safer sex practices for persons with HIV.

### **4. Laboratory Services.**

Our department has been a CLIA certified moderate complexity lab, which we are now changing to a PPM lab. We will provide limited diagnostic and screening tests for our clients in the family planning and sexually transmitted disease programs.

## **5. Medical Examiner**

The Medical Examiner in Coos County works out of the District Attorney's office.

## **6. Nutrition.**

Nutrition education and counseling is the primary focus of the WIC program. Nutrition counseling is also a component in our maternal child services, family planning, and Ryan White services. Funds have not been available to do community-wide promotion activities, e.g., for weight control and prevention of heart disease.

## **7. Older Adult Health.**

This department provides flu shots and other immunizations to our older population. We no longer administer the Breast and Cervical Prevention Program, but we hope to be a contracted provider for these services for women age 50-64. Older adults may receive services through Ryan White (for those with HIV) and benefit from any community education that we provide to the general population. Our department does not have funds to target other important health issues for elders, such as arthritis and cardiovascular health.

## **8. Primary Health Care.**

Our department does not provide primary health care. We assist with the application process for the Oregon Health Plan, and we refer to local medical providers, including the local safety net providers in the Waterfall Clinic. Although our federal grant for the Healthy Communities Access Program has ended, we continue to provide limited assistance to persons seeking publicly funded insurance, and prescription assistance. Through Oregon Mothers Care, we help pregnant women get into prenatal care and apply for financial assistance. With the cutbacks on the Oregon Health Plan eligibility, however, the numbers without health insurance are increasing.

## **9. Shellfish sanitation.**

Services are provided locally through the Oregon Department of Agriculture (ODA). Commercial shellfish harvesting is regulated by ODA under ORS 622 and standards set by U.S. Food and Drug Administration. ODA provides routine updates to the public and Coos County Public Health on status of shellfish harvesting in specific coastal areas. If circumstances warrant, Coos County Public Health may take additional steps to alert the public to related sanitation issues.

**Action Plans**

**For**

**Each of the Five Basic Services**

## **Control of Communicable Disease Action Plan 2007/2008**

### **Current Condition or Problem:**

Coos County investigated 314 reports of communicable disease during FY 2005/2006. The cases of selected reportable diseases during CY 2005 are as follows:

AIDS – 1 case in 2005; HIV - 0 cases (4 in 2003)  
Chlamydia –115 cases, (130 in 2004)  
Gonorrhea – 2 cases, (7 in 2004)  
Hepatitis A - 0 cases (5 in 2004)  
Hepatitis B – 1 acute case and 6 chronic cases (2 acute in 2004)  
Hepatitis C (chronic) – 48 cases; processed 159 lab reports for Hepatitis C  
Pertussis – 5 cases in 2005 (3 in 2004)  
Meningococcal disease – 3 cases  
Giardiasis – 8 cases.

1. Coos County Public Health (CCPH) continues to respond to communicable disease calls 24/7. We have trained individuals in basic BT/CD Epidemiology (CD 101), and also CD 303. One Environmental Health Specialist is also trained in CD 101 and 103, and the other EH specialist will also be trained to respond to questions and concerns when it is applicable to their field.
2. Investigations of reportable conditions and communicable diseases are conducted, control measures are carried out, and investigation report forms are completed and submitted as per the Investigative Disease Guidelines.
3. On-going training of staff is aimed at improving our ability to work in coordination with all of our community partners to improve communicable disease response. These partners include, but are not limited to: local hospitals, emergency medical services, fire, police, county emergency management, local volunteer agencies, local CERT teams, and state communicable disease personnel.
4. Immunizations for human target populations, such as those at risk for Hepatitis, are available here in the Health Department. Rabies immunizations for animal target populations are available within our jurisdiction, and rabies treatment inoculations are available locally at Bay Area Hospital.
5. We continue to receive and distribute public health alerts. Information is provided to the local providers via fax broadcast, e-mail and local media. We will continue to test this system periodically to identify any problem areas, and to keep all the contact information updated. This system is also in place for contacting city municipalities, public safety officers (fire & police), and veterinarians.
6. We have tried using the Oregon Alert system within our department to provide another means of communicating information for our emergency response, and look forward to improvements in this state system.
7. CCPH continues to work closely with Oregon Health Services/ Acute & Communicable Disease Program (OHS/ACD). We have contacted the on-call epidemiologist after

working hours on more than one occasion, and have had success using the OHS/ACD paging service. The epidemiologist on call has returned our call in a timely manner and has been able to assist us in the investigation via telephone consultation.

### **Goals:**

- To continue to be prepared to identify and respond to reports of communicable disease outbreaks 24/7.
- To continue to complete and submit CD investigation documentation within the mandated timelines, > 90% of the time.
- To continue to provide education to the community on protection from potential illness and/or exposures.

### **Activities:**

- Maintain “on call” pager schedule for trained CD staff for 24/7 coverage.
- Distribute information received from CDC, Health Alert Network, and other sources to appropriate community partners.
- Continue active & passive surveillance of community illness/reportable diseases and/or syndromes.
- Update the county website with pertinent information on communicable diseases and/or public health preparedness topics.
- Train any nurses new to the department in CD response, and provide continuing education to the public health staff about their duties and responsibilities during a communicable disease outbreak.
- Work with Tribal officials for a coordinated response to outbreak investigations.
- Investigate all reported communicable diseases/conditions within the investigative guidelines.
- Continue to test current communication capabilities, such as fax and email, with all local partners to ensure ability to distribute information during emergency situations.
- Make contact with the local laboratories and infection control practitioners on a periodic basis to encourage reporting.

### **Evaluation:**

Meet the performance time lines for investigation and submission of forms to DHS/ACD.

Log the number of community outreach activities.

Tabulate the results of communications testing.

### **Challenges:**

Funding continues to be inadequate to meet the requirements of this contract program element.

## **Tuberculosis – Action Plan 2007/2008**

### **Current Condition or Problem:**

In FY 2005/2006, our nurses investigated 4 possible cases of tuberculosis, of which 2 were found to be active cases. Latent tuberculosis infection (LTBI) continues to be identified in the county. During the past fiscal year, 4 individuals received antibiotic treatment and monthly evaluation for latent tuberculosis. These numbers are down from 2003 when we had 15 LTBI patients. Most cases have been identified during testing for purposes such as immigration, employment, and school admission. Nurses performed skin testing for 141 individuals.

### **Goals:**

- Accurately identify active and latent TB cases in the community.
- Ensure that the active tuberculosis cases receive Directly Observed Therapy (DOT), as necessary, for the duration of therapy appropriate to their cases.
- Contact all persons with latent disease to discuss the appropriateness of antibiotic therapy.

### **Activities:**

- Public health nurses and the Health Officer will continue to work cooperatively with Department of Human Services/Health Services and local medical providers to provide evaluation of positive PPD skin tests.
- Provide state supplied medication at no cost to those clients without medical insurance and/or limited resources when appropriate.
- Ensure that follow-up sputum testing is done at the appropriate intervals during treatment of active TB.
- Provide TB testing via the PPD method as requested and provide timely follow-up testing and treatment for any contacts to a person with known or suspected active TB, using the investigative guidelines.
- Submit appropriate completed forms to the state TB division at the initiation of therapy, as further information is available, and at the completion of therapy for both active and latent disease.

**Evaluation:**

- Timely investigation and identification of index cases and contacts.
- Accurate and complete documentation of completion of treatment and/or case management of clients, according to CCPH protocols.

**Challenges:**

Provision of DOT to active cases of TB is a challenge due to budget constraints at the local level, and minimal financial support for this work from the state. The state does continue to provide the appropriate medications for treatment of both LTBI and active TB to the county at no cost. The actual cost for follow up and management of active TB cases requiring DOT far exceeds the amount of funding provided. Patients with latent disease are seen and evaluated monthly, requiring allocation of nursing hours, and administrative costs. We will continue to provide services to the best of our ability. However, lack of resources may limit our response capability, eventually, and that will result in a risk to the community. Active tuberculosis, if untreated, could lead to an epidemic with devastating consequences.

Plan A - Continuous Quality Improvement: 4<sup>th</sup> DTaP rate at the Coos County Health Department  
**Fiscal Years 2006-2008**

Year 1: July 2005 – June 2006				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p><b>A. Develop a plan to increase the 4<sup>th</sup> DTaP rate 10% over the next 3 years.</b></p>	<ul style="list-style-type: none"> <li>• Use AFIX to assess the baseline rate of the 4<sup>th</sup> DTaP.</li> <li>• Develop a P&amp;P to increase the 4<sup>th</sup> DTaP rate. The P&amp;P will include forecasting the 4<sup>th</sup> DTaP, when to administer the 4<sup>th</sup> DTaP, and a template letter about the increase of Pertussis in Oregon and the importance of the DTaP series.</li> <li>• Use AFIX to identify children <math>\geq 24</math> months of age who have not received the 4<sup>th</sup> DTaP, and mail a copy of the letter to their parents.</li> <li>• Use AFIX to reassess the 4<sup>th</sup> DTaP rate.</li> </ul>	<ul style="list-style-type: none"> <li>• Determine baseline rate of the 4<sup>th</sup> DTaP by July 1, 2005.</li> <li>• Develop and implement the 4<sup>th</sup> DTaP P&amp;P by October 1, 2005.</li> <li>• Identify children <math>\geq 24</math> months of age, and mail a copy of the letter by October 31, 2005.</li> <li>• Reassess the 4<sup>th</sup> DTaP rate by April 30, 2006.</li> </ul>	<ul style="list-style-type: none"> <li>• The 4<sup>th</sup> DTaP rate in 2004 was 59%.</li> <li>• The 4<sup>th</sup> DTaP P&amp;P was approved and implemented on March 29, 2006.</li> <li>• ~ 25 letters were mailed in Dec 2005. ~ 50 letters were mailed in Mar 2006.</li> <li>• The 4<sup>th</sup> DTaP rate in 2005 was 71%.</li> </ul>	<p>The P&amp;P includes a reminder system for children 2-35 months. The system includes 248 children. Additional time was needed to review records in Ahlers, IRIS, and ALERT, the Oregon immunization registry. Some children had duplicate records in Ahlers, IRIS, and ALERT that needed to be merged. Before duplicates could be merged, data needed to be verified to determine that the records were for the same child and not two different children. If DTaP dose #2 or #3 is due, a reminder postcard is mailed. If DTaP dose #4 is due, the 4<sup>th</sup> DTaP letter is mailed. Reminders are mailed monthly.</p> <p>The Health Department increased the 4<sup>th</sup> DTaP rate over 10% during the last year.</p>

## Plan A - Continuous Quality Improvement: 4<sup>th</sup> DTaP rate at the Coos County Health Department

Year 2: July 2006 – June 2007				
Objectives	<u>Methods / Tasks</u>	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. Increase the 4 <sup>th</sup> DTaP rate 5% in 2006.	<ul style="list-style-type: none"> <li>Evaluate the effectiveness of the 4<sup>th</sup> DTaP rate P&amp;P and revise as needed.</li> <li>Monthly reminders will be mailed to the parents of children 2-35 months of age who are due for a DTaP.</li> <li>Obtain annual AFIX assessments of the 4<sup>th</sup> DTaP rate.</li> <li>Use AFIX to reassess the 4<sup>th</sup> DTaP rate.</li> </ul>	<ul style="list-style-type: none"> <li>Revise the 4<sup>th</sup> DTaP rate P&amp;P as needed by December 31, 2006.</li> <li>Reminders will be sent by the last business day of the month.</li> <li>Annual AFIX assessments will be obtained during the annual Immunization Conference.</li> <li>The 4<sup>th</sup> DTaP rate will increase 5% during 2006.</li> </ul>	To be completed for the FY 2007 Report	To be completed for the FY 2007 Report

**Plan A - Continuous Quality Improvement: 4<sup>th</sup> DTaP rate at the Coos County Health Department**

Year 3: July 2007 – June 2008				
<b>Objectives</b>	<b><u>Methods / Tasks</u></b>	<b>Outcome Measure(s)</b>	<b>Outcome Measure(s) Results</b>	<b>Progress Notes</b>
A. Increase the 4 <sup>th</sup> DTaP rate another 5% in 2007.	<ul style="list-style-type: none"> <li>• Hold a meeting with Maria Grumm, PHN, from the DHS IZ program to educate staff regarding dealing with parents opposed to multiple immunizations.</li> <li>• Obtain annual AFIX assessments of the 4<sup>th</sup> DTaP rate.</li> <li>• Use AFIX to reassess the 4<sup>th</sup> DTaP rate.</li> </ul>	<ul style="list-style-type: none"> <li>• The meeting to educate staff will be in September 2007.</li> <li>• Annual AFIX assessments will be obtained during the Annual Immunization Conference.</li> <li>• The 4<sup>th</sup> DTaP rate will have increased 5% in 2007.</li> </ul>	To be completed for the FY 2008 Report	To be completed for the FY 2008 Report

Plan B - Chosen Focus Area: Vaccine Accountability with Private Providers Fiscal Years 2006-2008

Year 1: July 2005 – June 2006

Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<p><b>A. Develop a plan to decrease the five private provider's VFC vaccine unaccountability rate to &lt;5% over the next 3 years.</b></p>	<ul style="list-style-type: none"> <li>• Use ALERT to assess baseline vaccine unaccountability rates for each of the five private clinics that provide VFC vaccine.</li> <li>• Obtain Standard Operating Procedures (SOPs) from the DHS for vaccine management.</li> <li>• Work with each of the five private providers to develop SOPs for their clinic.</li> </ul>	<ul style="list-style-type: none"> <li>• Baseline unaccountability rates for the five private clinics will be assessed by October 1, 2005.</li> <li>• SOPs will be obtained by January 1, 2006.</li> <li>• All private clinics that provide VFC vaccine will develop SOPs by June 30, 2006.</li> </ul>	<ul style="list-style-type: none"> <li>• The HD is unable to access unaccountability rates due to the private clinics confidentiality rights.</li> <li>• SOPs were obtained by January 1, 2006. Copies were mailed to the five private clinics on March 21, 2006.</li> <li>• On March 21, 2006, four of the five private clinics had written P&amp;P regarding vaccine management.</li> </ul>	<p>During the 2005 Annual Immunization Luncheon, Jenne McKibben, DHS Health Educator, discussed storage and handling of vaccine. Also in 2005, the five private clinics that provide vaccine in Coos County completed an accountability check list. According to the results, all five clinics are in compliance with the DHS guidelines for vaccine storage and handling. Four of the five private clinics have written P&amp;P in place for vaccine management. All five clinics have been provided copies of the DHS SOPs to update/develop their P&amp;P for vaccine management as needed.</p> <p>Coos County Health Department had met its goal in educating the private clinics regarding vaccine management, and will be changing the focus for the next two years to developing an immunization coalition.</p>

Plan B - Chosen Focus Area: Developing an Immunization Coalition

Year 2: July 2006 – June 2007

Objectives	<u>Methods / Tasks</u>	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. Develop an immunization coalition.	<ul style="list-style-type: none"> <li>• Identify agencies interested in participating in an immunization coalition.</li> <li>• Hold two immunization coalition meetings.</li> <li>• Identify the immunization coalition goals and action steps for the next two years.</li> </ul>	<ul style="list-style-type: none"> <li>• The immunization coalition will include participation from the Health Department, Bay Area Rotary Club, Bay Area Hospital, Coquille Tribe, North Bend Medical Center, Bay Clinic, and Powers Clinic.</li> <li>• The first immunization coalition meeting will be held by October 1, 2006. The second immunization coalition meeting will be held by April 1, 2007.</li> <li>• The immunization coalition goals will be identified during the first meeting. The goals will then be reassessed during the second meeting.</li> </ul>	To be completed for the FY 2007 Report	To be completed for the FY 2007 Report

## Plan B - Chosen Focus Area: Developing an Immunization Coalition

Year 3: July 2007 – June 2008				
Objectives	<u>Methods / Tasks</u>	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
A. Maintain the immunization coalition.	<ul style="list-style-type: none"> <li>• Hold immunization coalition meetings biannually.</li> <li>• Develop an immunization resource list to distribute to coalition partners.</li> <li>• Reassess the coalition goals.</li> </ul>	<ul style="list-style-type: none"> <li>• Immunization coalition meetings will be held in October and April.</li> <li>• A list of immunization resources will be distributed to partners during the October meeting.</li> <li>• The coalition goals will be reassessed during the April meeting.</li> </ul>	To be completed for the FY 2008 Report	To be completed for the FY 2008 Report

## Outreach Activities: July 2005 – June 2006

Activity 1:				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results	Progress Notes
<b>A. Educate three state-certified daycares and/or preschools staff regarding immunizations and Oregon state law.</b>	<ul style="list-style-type: none"> <li>Perform three validation surveys with assistance from Amanda Timmons, DHS Health Educator on School Law.</li> </ul>	<ul style="list-style-type: none"> <li>Select three daycares and/or preschools by April 1, 2006.</li> <li>Perform three validation surveys by May 2006.</li> </ul>	<ul style="list-style-type: none"> <li>Four daycares/preschools were selected by April 1, 2006.</li> <li>Dates for the validation surveys are pending.</li> </ul>	Amanda Timmons is currently scheduling dates for the validation surveys.

Activity 2:				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results <sup>1</sup>	Progress Notes <sup>2</sup>
A. Educate public and private providers on ways to increase immunization coverage rates.	<ul style="list-style-type: none"> <li>Assist with the annual AFIX meeting to be hosted by the DHS IZ program AFIX team.</li> </ul>	<ul style="list-style-type: none"> <li>The annual AFIX meeting will be held in June 2006.</li> </ul>	<ul style="list-style-type: none"> <li>The annual AFIX meeting is scheduled for May 11, 2006.</li> </ul>	<p>Plans for the annual AFIX meeting are currently in progress.</p> <p>Amanda Timmons will also be present to discuss school law and the ACIP schedule.</p>

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## **Increase Access to Early and Adequate Prenatal Care – Action Plan 07/08**

### **Current Condition or Problem**

In 2004, 8.2% of pregnant women in Coos County received inadequate prenatal care (defined as fewer than 5 visits before the third trimester), compared to the state rate of 5.8%. In 2004, 78.4% of all pregnant women in Coos County received prenatal care in the first trimester compared to the state rate of 80.4. Of the women enrolled in our Maternity Case Management program this past year, 77.6% received early prenatal care during their first trimester.

The following statistics reflect the 89 women served in our Maternity Case Management program for the 2005-2006 year:

- 77.6% received early prenatal care (within the first trimester of pregnancy)
- 78.9% were unplanned pregnancies
- 99% had nutritional risk factors
- 98% had oral health issues
- 62.2% were unmarried
- 54% of women were 19 years or younger. Nine percent (9%) were 17 years or younger, compared to the 2004 county rate of 3.1% and the 2004 state rate of 2.8%
- 24% had less than a high school education
- 35% were victims of domestic violence
- 44.3% had a current or history of mental health issue(s)
- 43% used tobacco compared to the 2004 county rate of 23.5% and the 2004 state rate of 12.6%. Of those MCM clients who smoked, 44.2% quit or decreased their smoking during their pregnancies.
- 16.9% admitted to using alcohol, compared to the 2004 county rate of 0.9% and the 2004 state rate of 1.5%. Of those MCM clients who drank, 100% quit during their pregnancies.
- 14.6 % admitted to using or having used drugs compared to the 2004 county rate of 3.9% and the 2004 state rate of 1.8%. Of those clients who admitted to using drugs, 95.8% quit during their pregnancies.
- 17.6% of births were premature.
- 11.8% of infants had birth weights < 2500 grams, compared to the 2004 county rate of 17.2% and the 2004 state rate of 11.8%

Client satisfaction surveys showed an average score of 4.8 out of a possible 5, achieving our 2006 goal.

Early prenatal care is important because:

- Complications to mother or fetus can be identified early and managed.
- There is adequate time to make referrals to smoking/drug/alcohol cessation programs, as substance use has been associated with low birth weight babies, preterm labor, sudden infant death syndrome, stillbirths, ectopic pregnancies, fetal alcohol syndrome, birth defects, and other conditions.

- Existing medical problems, such as hypertension and diabetes, can be better managed. (If uncontrolled, these have been associated with poor pregnancy outcomes for both mother and fetus.)
- It allows time to address psycho-social issues and make referrals to other agencies such as WIC, DHS-SSP, and the Housing Authority, to address a client's basic needs.

The identified barriers to early prenatal care include the following:

- Denial of pregnancy or lack of recognition of pregnancy until later into the gestational period
- Procrastination
- Low education levels
- No medical insurance
- Ignorance of the Oregon Health Plan requirements and difficulty with the application process
- Drug/alcohol issues
- Language barriers for Spanish speaking population (difficulty applying for OHP, communicating with prenatal care providers, few materials translated, few staff who speak Spanish)
- Mental health issues/conditions
- Previous involvement with Child Welfare Protective Services

Other access problems to prenatal care that have been identified include:

- Lack of prenatal care providers in areas outside North Bend/Coos Bay; lack of prenatal care providers who speak Spanish.
- Lack of transportation to medical services, especially with the decrease in frequency of bus routes/stops.
- Late (after the first trimester) referrals to the Health Department for Maternity Case Management (MCM) and other services by other community providers.
- Lack of smoking cessation support groups
- Lack of easy access and treatment for dental care during pregnancy

### Goals

- Increase access to comprehensive prenatal care by addressing barriers.
- Increase the percent of pregnant women enrolled in the MCM program who initiate prenatal care within the first trimester by 5% over the 2006-2007 baseline.
- High level outcome: **Strong nurturing families and healthy thriving children.**

### Activities

- Assist pregnant clients with applications to the Oregon Health Plan and facilitate pregnant women's first appointments with prenatal care providers, through the Oregon Mother's Care (OMC) Program.
- Refer pregnant clients from internal Public Health Department programs such as WIC and pregnancy testing to Oregon Mothers Care (OMC) and maternity case management (MCM) programs, and promote these services to other agencies that serve pregnant women.

- Provide prenatal and postpartum home visits through the Health Department's MCM program. Home visiting nurses support pregnant women in maintaining prenatal care and healthy behaviors that support positive pregnancy outcomes.
- Coordinate distribution of prenatal vitamins to eligible women per March of Dimes grant guidelines.
- Coordinate education and distribution of dental kits and xylitol gum kits to eligible women per Oregon Dental Foundation grant guidelines.
- Continue to meet monthly and work with the Perinatal Task Force (PNTF) to assess and plan ways to improve the early prenatal care rates in Coos County. The PNTF includes representatives from Bay area Hospital, Public Health, DOCS – Independent Practice Association, A & D treatment, DHS Food Stamps/Temporary Aid to Needy Families, and physicians and other organizations.
- Assist with the Perinatal Task Force's new perinatal depression group, "Survival Skills for New and Parenting Moms," that provides 4 weeks of education to pregnant and postpartum mothers, and a follow-up support group.
- Continue to promote the importance of dental care during the second trimester of pregnancy to prenatal care providers and work with local dental providers in ensuring dental care is offered/provided to pregnant women in a timely fashion. Continue to coordinate meetings with the dental community on a semiannual basis to facilitate pregnant women's access to timely dental care.
- Collect specific data on infant gestation, birth weight, birth defects, and maternal use of substances and their quit rates during pregnancy.
- Work with the Latino Outreach Committee to address barriers to providing services to the Spanish-speaking population.
- Work with the Clean Air Coalition to address smoking cessation issues, such as coordinating a smoking cessation training for health care providers.
- Attempt to locate additional sources of funding to help support the MCM program.
- Encourage state nursing consultants to work with OMAP and other policy makers to increase MCM reimbursement rates, considering that service to an MCM client actually is benefiting the health and wellness of 2 clients (mother and unborn child).

### **Evaluation**

- ✓ Improvement in the rate of pregnant women who receive first trimester prenatal care
- ✓ Maintaining a score of 4.5 or better (out of a possible 5) on a satisfaction survey of clients served in the Maternity Case Management Program
- ✓ Number of pregnant women served through Oregon MothersCare who have successfully initiated prenatal care
- ✓ Log of the number of community outreach activities

### **Challenges**

- The state support for perinatal services is insufficient for the number of women who can be served with Maternity Case Management
- The medicaid reimbursement rate for MCM services does not reflect the actual cost of providing these services

Barriers to access for adequate and timely oral health for pregnant women include: transportation; few dental providers accepting the OHP, resulting in long waits for an initial appointment; communication barriers for Spanish speaking families; overall poor oral health status prior to pregnancy; and lack of oral health education prior to enrollment in the MCM program.

## **Infants and Children Will Have Nurturing Caregivers (and Decreased Child Abuse) Action Plan 2007 - 2008**

### **Current Condition or Problem**

The statistics for child abuse showed that Coos County ranked 7<sup>th</sup> in the state with a rate of 21.3% in 2005, up from 15.6% in 2004. The state rate is 12%. In 2005, there were 781 reports of child abuse and neglect and 154 foster care entrants. Major family stressors that contribute to Coos County's child abuse/neglect rates are drug and/or alcohol abuse, parental involvement with a law enforcement agency, unemployment, and domestic violence. Other contributing factors are: low income, limited education, and poor parenting (the most prevalent factor according to the Child Welfare System). However, poor parenting is often generational and may be influenced also by the factors listed above. The major reasons for placement in foster care were drug and alcohol abuse, physical abuse, neglect, the child's behavior, inability to cope, and inadequate housing.

### **Goals**

Reduce child abuse and neglect.

High level outcome: **strong nurturing families and healthy thriving children.**

### **Activities**

Research shows that early intervention into the lives of families, beginning in and including the prenatal period, has a high impact on parental success and lessens child maltreatment.

- Provide prenatal and postpartum home visits through the Department's Maternity Case Management (MCM) program. Public Health Nurses support pregnant women in maintaining prenatal care and healthy behaviors that promote good outcomes in pregnancy and preparation for parenting.
- Educate mother in the MCM program about healthy lifestyle choices related to nutrition, early childhood cavities prevention, importance of avoiding tobacco, drugs and alcohol.
- Educate mothers in the MCM program about common parenting topics such as parent-infant bonding during prenatal and postpartum periods, parental frustrations, sleep deprivation, child nurturing/protection, infant communication/bonding, and signs of postpartum depression.
- Educate mothers in the MCM program about key infant care topics such as well-child care, immunizations, safety/emergencies, lead exposure prevention, feeding/nutrition, sleep patterns/position, and child passenger safety.
- Provide home visits through the **Babies First!** program for children at risk of developmental delay due to a variety of risk factors including: premature birth; drug exposed infant during pregnancy; low birth weight; age of the parent/caregiver; low income/ poverty and many other factors. **Babies First** targets children from birth through age four. Potential problems can be detected quickly and interventions started and

monitored regularly. Public health nurses conduct in-home health and developmental screening for participating children on a regular basis. The nurses work closely with the families on parenting skills, health education, advocacy, and referrals to services in other agencies. **Babies First** focuses on helping families learn to care for and better understand their children. Case management activities help link families to needed community resources and providers.

- Provide monthly home visits (or more often if needed) after birth and up to age 5, in the **Parents as Teachers** program. Parent educators (nurses or paraprofessionals) use a best practices curriculum to help parents learn positive parent-child interactions, child development, realistic expectations, and coping skills. The program provides information and guidance to reduce child abuse and neglect and promote “readiness to learn.” During the visits, educators help parents understand what to expect in each stage of their child’s development, and offer practical tips on ways to encourage learning, manage challenging behavior, and promote strong parent-child relationships. Screening is done for overall development, language, hearing, and vision. Case management activities help link families to needed community resources and providers.
- Provide nursing case management for children with special health care needs through the **CaCoon** program. Nurses assist parent with medical, nutritional, and developmental issues and promote positive coping skills. Parents are helped to identify and prevent problems related to their child’s special health condition. Screening is done for growth and development and referrals are made into early intervention when needed. Nurses also coordinate health care and specialty services.
- CaCoon Nurse will participate in Community Connections as needed and as able, considering the limitations of funding.
- Provide the Healthy Start program to first time families identified as eligible to receive Healthy Start services. This program was transferred to CCPH in fiscal year 06-07. Healthy Start staff is working under the guidance of the state Healthy Start Coordinator, and are receiving close consultation with state staff as needed. Policies and procedures are being developed that adhere with the state Healthy Start and CCF protocols. This program fits well into CCPH’s existing continuum of home visiting programs.
- Plan on sending a new Healthy Start employee to receive training in the Parents as Teachers training. This will help to provide a continuity of parent education provided by all home visitors in the Family Health Field Services staff.
- Assist with the newly formed perinatal depression group, which was recently formed through a collaborative effort of our local Perinatal Task Force. The depression group consists of a 4 week curriculum “Life with a New Baby in the Home,” that is then followed by a support group for those who have graduated from the class. Since research shows that new moms who have a history of depression often miss or misinterpret their babies’ cues, this intervention for the mothers’ depression can be important for the ultimate development of the mother/child attachments.

- Continue to develop rapport with local and regional dental community to improve access and treatment of pregnant women and young children to promote early childhood cavities prevention.
- Seek funding opportunities through grants and/or contracts to help support MCM services.
- Seek funding opportunities through contracts with local providers to help support Parents as Teachers/Babies First home visiting programs.
- Continue to participate in development of state DHS/Family Health Field Services Family Net Database (Perinatal MDE/ORCHIDS)
- Work with regional dental consultants to possibly plan for setting up a dental clinic to assess our Family Health home visiting clients as well as WIC clients.
- Family Health Field Services Program Manager will continue to participate in local MDT and Child Fatality Review Board.
- Family Health Field Services staff will continue to participate in DHS: Child Welfare Services's System of Care meetings.
- Family Health Field Services staff will continue to participate in Family Violence Council meetings.
- Our Family Health Field Services Public Health Nurse who has been a long term nurse working in Parents as Teachers, and providing part time contract work to Mental Health, will be contracted full time this year to focus on Infant Mental Health.
- Plan to send Family Health Field Services Program Manager to "Circle of Security" training to then be able to provide more in depth training to remainder of staff on issues related to attachment.
- Plan on sending at least 1-2 field staff to annual Child Abuse Summit, if funding available.
- Invite local Women's Safety and Resource Staff to provide an inservice on domestic violence for both general and maternal child health staff.

## **Evaluation**

For families served by **Maternity case Management:**

85% of the families surveyed and enrolled will state:

1. services helped them feel more confident about becoming a parent.
2. services provided them with information about what to expect during pregnancy and birth during the newborn period.

3. services resulted in their being informed of helpful resources in the community.

For families served by **Parents as Teachers:**

- Families needs will be identified in 100% of clients.
- 80% of parents will demonstrate positive child-rearing competencies and improved parenting skills
- 80% of parents will demonstrate positive parent-child interactions.
- 80% of parent s will demonstrate increased knowledge about child development.
- 80% of parents will demonstrate developmentally appropriate expectations.
- 90% of parents will have no confirmed case of abuse/neglect after enrollment into Parents as Teachers
- 90% of enrolled parents will self report improved access and utilization of services
- 90% of parents will report supportive relationships with others

For families served by **Babies First and CaCoon:**

- evaluations will be conducted by the state, and our staff will participate as needed.

For families served by Healthy Start:

- evaluations will be conducted by the state and local Commission on Children and Families.

## **Decrease Prenatal Tobacco Use – Action Plan 2007/2008**

### **Current Condition or Problem**

Smoking during pregnancy is a problem for the fetus, because nicotine passes the placental barrier and the carbon monoxide in tobacco smoke combines with hemoglobin to reduce the oxygen-carrying capacity of the blood. These factors contribute to complications such as slower fetal growth, low birth-weight, an increased risk of miscarriage, premature labor, an increased risk of stillbirth and pre-term delivery. These babies also have a greater risk of developing health problems within a few months after birth, such as asthma, allergies, ear infections, sudden infant death syndrome (SIDS), and lifelong disabilities. In addition, there is a possible link between smoking by a mother and attention deficit disorder (hyperactivity) in children.

According to the latest statistics, 23% of pregnant women in Coos County used tobacco, nearly twice that of the state rate of just over 11%. Currently, Coos County is ranked 4<sup>th</sup> highest in the state for pregnant women who smoke.

Nearly 43% of the women enrolled in our Maternity Case Management (MCM) program in 2005-2006 used tobacco products during their pregnancies. While we may have had a disproportionate number of smoking women enrolled in our MCM program compared to the county, 56.8% of these women were successful in their efforts to quit or decrease their smoking.

### **Goals**

- Decrease the number of pregnant women who use tobacco while enrolled in MCM from 43% to 25% or less
- Increase the number of tobacco interventions given by health care providers to women of childbearing age
- Continue to offer 5As cessation trainings to health care providers
- Promote the use of the Oregon Tobacco Quitline by Coos County residents and smoking cessation resources (such as Fresh Start Family and DOCS)

### **Activities**

- Continue to use the 5As of cessation protocol in home visiting programs, WIC, and during family planning visits for women of childbearing age.
- Continue to offer/provide 5As cessation and motivational counseling trainings to various community partners. If funding is available, bring in speaker to provide local training for health care providers focusing on the 5 A's, motivational counseling, and stages of change.
- Continue to participate in the Clean Air Coalition and work with community partners to increase awareness and knowledge of the dangers / consequences of tobacco use during pregnancy.

- Continue to promote established cessation programs to prenatal care providers, case management providers, and healthcare personnel.
- Continue to refer to the Oregon Tobacco Quit Line, and local cessation programs.
- Collaborate with Tobacco Prevention Program 's Public Health Educator in tobacco related projects for pregnant women

**Evaluation**

- WIC, Family Planning, MCM, and other home visiting programs will track the smoking status of their clients
- The 2006 Oregon DHS Center for Vital Statistics database will show a decrease in the number of pregnant women in Coos County who use tobacco

**Family Planning -- Action Plan 07-08**  
**Reduce the Risk of Unintended Teen Pregnancy**  
**Assure High Quality Family Planning Services**

**Current Condition or Problem**

In 2005, there were an estimated 3,032 *women in need* (WIN), ages 13-44, according to Region X data. Our family planning clinic served 1,686 unduplicated or 56% of the WIN, compared to the previous year's statistics of 1,793 clients and 59.1% of WIN. The data also showed that there were 772 female teens ages 13-19 years in need of services, and our clinic served 570, or 74%, a reduction from 629 teens, or 81% the previous year. Teen clients comprised 33% of the total clients that were served in the Family Planning Clinic, without considering WIN statistics.

Our teen pregnancy rates have decreased over the past few 5 years, with a rate of 10.2 per 1000 girls age 10-17 in 2002, 7.8 in 2003, and 7.3 in 2004 (state rate 9.5 in 2004). The rolling rate for 2005, however, shows an increased rate of 9.1. The rolling rate for 2005 rises sharply to 21.2 per 1000 if only 15-17 year olds are counted, compared to the rate of 17.4 in 2004. Many of these late adolescent/young adults seem ill equipped for life and parenthood because of low paying jobs and limited ability to improve their earnings in the future because of lack of opportunity and education. The U. S. Census Bureau tells us that in 2000, about 82% of our county young people graduated from high school, but only 15% of persons in the county age 25 plus have a bachelor's degree or higher.

Funding to sustain our family planning services is becoming more challenging. Each year we are serving more clients who are not eligible for FPEP, or Oregon Health Plan, and who do not pay for services. Both Title X and county funds have decreased, as have the reimbursement rates from Medicaid. The local Waterfall Clinic became an FPEP provider in 2006, and provides family planning services to the same client pool that we serve.

Outreach activities have occurred on the local community college campus and at special community events for teens (Teen Summit and Teenopoly). Family planning clinic days at the Coquille satellite office were increased in January of 2007 from once a month to weekly appointments. The Students Today Aren't Ready for Sex (STARS) abstinence program was provided in 4 middle schools this past fiscal year with the assistance of an Americorp member. Fifty high school students were trained as teen leaders and 434 middle school students completed the program. This program may be discontinued in 2007/08 due to lack of funds.

**Goal 1: Assure continued high quality clinical family planning and related preventive health services to improve overall individual and community health.**

<b>Problem Statement</b>	<b>Objective(s)</b>	<b>Planned Activities</b>	<b>Evaluation</b>
Changes in FPEP enrollment have led to increased staff time without additional reimbursement, threatening the ability of the agency to maintain current level of service.	1) Increase revenue from donations by 10% for the period ending June 30, 2008	Develop a donation policy and procedure consistent with Title X guidelines. Train staff in positions to make the donation requests. Implement donation request policy. Evaluate policy for consistency, fairness and effectiveness	Quarterly and fiscal year end revenue reports Customer feedback Staff feedback

**Goal 2: Assure ongoing access to a broad range of effective family planning methods and related preventive health services.**

<b>Problem Statement</b>	<b>Objective(s)</b>	<b>Planned Activities</b>	<b>Evaluation</b>
Unable to offer IUDs due to untrained staff.	1 NP will be able to offer IUD insertions by September 30, 2007	Identify IUD training events and resources. Paragard has been contacted and we expect a return call from the representative for our area. A local physician has been contacted and is willing to do some precepting. Support NP to attend an IUD training and preceptorship. Add IUD as a birth control option for clients	IUD training certificate # of IUDs inserted/removed

## FY 2006 - 2007 WIC Nutrition Education Plan Form

**County/Agency: Coos**

Person Completing Form: Phyllis Olson

Date: 4-10-2006

Phone Number: 541-756-2020 x520

Email Address: polson@co.coos.or.us

Direct questions to: Sara Goodrich, 971-673-0043

This section asks you to write the nutrition education plan(s) for the fiscal year 2006 – 2007.

**Goal 1:       Decrease the risk of obesity among WIC participants by increasing physical activity awareness.**

Activity 1:    **Required**

Assess your community's resources for safe, developmentally appropriate physical activity opportunities for families and their young children and provide a list of these resources to WIC clients.

Implementation Plan: Clients will be given a map of local parks, and free or low cost physical activity opportunities

Timeline: 8-01-2006

Activity 2:    **Required**

Make available to clients a 2<sup>nd</sup> nutrition education opportunity to increase physical activity.

Implementation Plan: The class "Being Active as a Family" will be offered in May and at least 3 more months in 2006.

Timeline: September, 2006.

Activity 1:    **Required**

Assess activities and resources in the community to promote fruits and vegetables and provide a list of these activities and resources to WIC clients.

Implementation Plan: We will provide a list of community gardens and farmers markets in the area. We will participate in issuing Farm Direct coupons.

Timeline: September, 2006

Activity 2:     **Required**

Develop and implement client-centered activity or event by June 2007 in recognition of 5 A Day.

Implementation Plan: Develop a clinic Bulletin Board devoted to 5 A Day.

Timeline: September 2006

Activity 1:     **Required**

Explore options for developing innovative partnerships for providing nutrition education to clients in your agency.

Implementation Plan: Contact OSU Extension and explore cooperating in additional nutrition education using their resources.

Timeline: December, 2006

Activity 2:     **Required**

Assess your agency's 2<sup>nd</sup> nutrition education offerings and make changes as needed to improve your show rates.

Implementation Plan: Offer classes more than once a month and vary times.

Timeline: Evaluate November, 2006

**Goal 4:            Increase breastfeeding duration rates among WIC participants.**

Activity 1:     **Required**

Assess breastfeeding resources available in your community and create and/or update a resource list for clients.

Implementation Plan: A breastfeeding resource list for Coos County will be updated and available for clients.

Timeline: October, 2006

Activity 2:     **Required**

Implement at least one new strategy to support clients' breastfeeding goals.

Implementation Plan: In coordination with the Coos County Breastfeeding Coalition, 3 major area employers will be contacted with the benefits of breastfeeding and becoming Breastfeeding Friendly Employers.

Timeline: March 2007

**Annual Report Form - WIC**  
**Evaluation of Nutrition Education Plan FY 2005-2006**

WIC Agency: \_Coos  
Person Completing the Form \_\_\_Phyllis Olson  
Date: \_\_4-10-2006

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Phone: \_\_\_541-756-2020

Direct questions to: Sara Goodrich, 971-673-0043

This section asks you to evaluate the nutrition education plan(s) you implemented during fiscal year 2005 - 2006. Answer the questions in "Outcome Evaluation" where a "response" is requested.

Please use the outcome evaluation criteria to assess the activities your agencies did for each Year 2 (i.e. 2005 – 2006) Objective. If your agency was unable to complete an activity, please indicate why.

**Goal 1: Decrease the risk of obesity among WIC participants by increasing physical activity awareness.**

Year 2 Objective:

During plan period, all WIC families will be provided information on the increasing rates of overweight children and adults and be able to make positive lifestyle choices to decrease the risk of overweight.

*Activity 1: Assess client awareness regarding physical activity and identifying client barriers to getting adequate physical activity by using state provided assessment tool. This activity was required.*

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

- What is one result from the client assessments that you have applied in your agency?

**Response: Not enough free or low cost physical activity programs for families with young children.**

*Activity 2: Using results from staff and client surveys, identify or develop, and implement at least one clinic activity to promote increased physical activity and increase awareness of the prevalence of overweight among staff and clients. This activity was required.*

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

- Identify 3 barriers or ideas you learned from the staff and client surveys.
- What clinic activities did you develop to promote physical activity?
- How did the activities address the barriers or concerns identified in the surveys?

**Response: Barriers to physical activity were:**

**Time, expense, and lack of safe areas to be active.**

**Coos WIC participated in a FIT WIC grant. Classes were held using the “Being Active as a Family” video. Clients from 3-5 years old were given activity bags, a booklet of fun indoor, inexpensive physical activities, lists of local parks, South Slough activity schedule, local swimming pool schedule and fees, and a free pass to Outdoor In ( a private indoor play area).**

**These were low cost options in safe places. We focused on short activities, not taking a great deal of time, and activity fitting in with a daily routine.**

**Goal 2: Increase the percentage of WIC participants who consume at least five daily servings of vegetables and fruits.**

Year 2 Objective:

During plan period, staff will assess and promote client consumption of fruit and vegetables.

*Activity 1: Assess client attitudes and behaviors regarding fruit and vegetable consumption using state provided tool. This activity was required.*

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

- What is one result from the client assessments that you have applied in your agency?

**Response: Fruits and vegetables are expensive. WIC Farmers Market coupons were promoted with ideas on choosing the best values.**

*Activity 2: Develop and implement a client centered activity or event during September 2005 in recognition of 5 A Day Month. This activity was required.*

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

- What client centered activity or event did your agency implement for 5 A Day month?
- How did your agency decide on this activity or event?
- What went well and what would you do differently?

**Response: We displayed a bulletin board with information on fruits and vegetables and ideas on using seasonal produce. We also displayed recipes using fruits and vegetables. We chose this activity due to staff time restraints and because it was highly visible to all clients. The information was well received and we are still hearing requests for more recipes.**

*Activity 3: Use client fruit and vegetable survey results to develop or modify individual or group nutrition education activities to promote fruit and vegetable consumption. This activity was required.*

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

- Identify 3 client attitudes or behaviors you learned from the surveys.
- What nutrition education activities did your agency develop or modify to promote fruit and vegetable consumption?
- How did the activities address the results from the surveys?

**Response: Three identified attitudes were: The expense of fruits and vegetables; whether they are offered frequently or seldom; and response to children's refusal to eat them. We offered a class on Fruits and Vegetables for 2 months. This included the division of responsibility (parents choose what is offered and when and children choose if or how much to eat) and actively involving other family members in produce selection and preparation. We promoted participation in Farmers Market and discussed ideas on choosing the best values.**

Goal 3: Increase client participation in 2<sup>nd</sup> nutrition education contacts.

Year 2 Objective:

Assess clients' attitudes, wants, needs and barriers regarding attendance to nutrition education opportunities; develop guidelines for nutrition education in your agency; and develop strategies to increase client participation in nutrition education. During the planning process, consider the impact of implementation of multiple month food instrument issuance (FLPP).

*Activity 1: Assess client attitudes, needs, and barriers to attendance related to 2<sup>nd</sup> nutrition education using state provided tool.*

Outcome Evaluation: Please address the following questions in your response. This activity was required.

- What is one result from the client assessments that you have applied in your agency?

**Response: Clients would like to choose day and time for 2<sup>nd</sup> nutrition education. Classes will be offered twice a month and at varied times. Clients will be advised that they may reschedule for a time convenient for them.**

*Activity 2: Compare results of client and staff surveys to state nutrition education minimum standards and develop guidelines for quality nutrition education in your agency. Minimum standards will be set in the areas of availability, accessibility, topic, content, delivery methods, marketing, assessment, and evaluation. This activity was required.*

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

- Identify 5 attitudes, needs, and or barriers you learned from the surveys.
- What guidelines did you develop for quality nutrition education?
- How did the guidelines address the results of the surveys?

**Response: The client surveys indicated:**

- 1. Breastfeeding class was indicated as one of the favorite. It will be offered twice a month at varied times.**

2. **Choosing time and day is important. Classes will be offered twice a month and clients will be encouraged to reschedule for a time convenient for them.**
3. **Hands-on workshops were popular and the frequency will be increased.**
4. **Almost half the respondents value videos for nutrition education and they will continue to be offered with group discussion.**
5. **Picky eaters-fruits and vegetables were a choice for more education. These classes will be offered and we will participate in Farmer's Market with an emphasis on child involvement in helping choose and prepare the produce.**

Guidelines for quality nutrition education:

Assessment: Client surveys were administered and sent to state for collation. The results were reviewed and analyzed.

Availability: Class times will vary and clients will be encouraged to reschedule for convenient appointments.

Topic and Content: Client preferences have been noted and these will be addressed in the offerings for the following year. Nutrition education offerings are available for all categories of clients.

Methods: Clients preferred hands on and video format classes and these will be the methods most commonly used.

Marketing: All current staff completed the "Marketing Nutrition Education" module. The new certifier will complete by July 1, 2006. WIC intake staff are reviewing classes offered so they can understand and encourage attendance.

Evaluation: WIC local agency Individual Education attendance from April, 2005 to February 2006 was 61%, Group Nutrition Education attendance was 51%.

After each nutrition education class the participants are asked to fill out an evaluation and these are reviewed and considered for changes that could be made.

*Activity 3: Contact your Nutrition Consultant to review your agency's guidelines, then plan and schedule 2<sup>nd</sup> nutrition education offering in preparation for multiple month food instrument issuance. This activity was required.*

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

- When did you and your Nutrition Consultant review your guidelines?
- How did your 2<sup>nd</sup> nutrition education plan offerings meet these guidelines?
- Have your 2<sup>nd</sup> nutrition education offerings been scheduled?

**Response: Guidelines were reviewed in September, 2005.**

**Local 2<sup>nd</sup> nutrition education offerings met these guidelines.**

**2<sup>nd</sup> nutrition education offerings are scheduled on a rotating basis depending on season and interest.**

*Activity 4: Assure staff who teach nutrition education classes complete the Providing Group Nutrition Education module and the appropriate Level 2 training modules. This activity was required.*

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

- Have all staff who teach nutrition education completed the Providing Group Nutrition Education module and the appropriate Level 2 training modules?

**Response: All staff who teach nutrition education have completed the Providing Group Nutrition Education module and the appropriate Level 2 training modules. The new Certifier will complete these modules by October, 2006**

Goal 4: Increase breastfeeding duration rates among WIC participants by decreasing barriers to breastfeeding.

Year 2 Objective:

During plan period, WIC staff will assess client attitudes, beliefs, and barriers regarding continuing breastfeeding to at least 6 months of age, and implement strategies to support client breastfeeding goals.

*Activity 1: WIC staff will have completed role-appropriate sections of the revised Breastfeeding Module. This activity was required.*

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

- Have all staff completed role-appropriate sections of the revised Breastfeeding Module?

**Response: All staff have completed role-appropriate sections of the revised Breastfeeding Module.**

*Activity 2: WIC staff will assess client beliefs, attitudes and barriers regarding continuing breastfeeding to at least 6 months of age by using state provided assessment tool. This activity was required.*

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

- What is one result from the client assessments that you have applied in your agency?

**Response: The client survey indicated mothers believed returning to work would mean a need for using formula. Efforts are being made to encourage mothers returning to work to continue to breastfeed. Breast pumps are available to mothers so they may pump breastmilk on their breaks and take home to the infant.**

*Activity 3: The WIC agency will implement at least one strategy to support client breastfeeding goals. This activity was required.*

Examples of possible strategies:

- WIC Certifiers will use the 3-Step Counseling Strategy to help mother's identify their barrier(s) to breastfeeding 6 months.
- Effective open-ended questions.
- Affirming statements.
- Education/counseling strategies.
- Include a goal setting objective that all prenatal women who indicate they plan to breastfeed will identify a goal related to breastfeeding 6 months.
- Include a participant activity during the Breastfeeding Class wherein participants identify at least one barrier they face to breastfeeding at least 6 months. As a group, identify strategies to address these barriers.
- Institute a system for follow-up calls or written messages at critical periods of time when breastfeeding challenges may arise.

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

- Did your agency implement at least one strategy to support breastfeeding goals?
- How did the strategy address the identified issue?

**Response: Open-ended questions are used to identify and address barriers to breastfeeding. This allows us to explore the issues of family support and public attitude.**

## **Health Statistics – Action Plan 2007/08**

### **Current condition or problem**

As one of the services required by Oregon law, our department registers all births and deaths in the county. We also review the health statistics which have been compiled by the state related to program areas that we provide. In some of our programs, we have not had a systematic approach to collecting health data or outcome measures that have not otherwise been required by the funding source.

### **Goal**

Continued improvement in departmental statistics gathering on health indicators or outcome objectives.

### **Activities**

- Each program supervisor will review tools and methods for collecting outcome data related to targeted program objectives.
- Where there are gaps in data collection, supervisors will develop tools or processes for measuring program effectiveness.

### **Evaluation**

Achievement of improved data collection in program areas.

## **Health Information and Referral Services - Action Plan 2007/08**

### **Current Condition or Problem**

Public Health clients often have needs that are out of the range of services offered within our department. Some are aware of the information or services they are seeking, and call asking for contacts and phone numbers. Many, however, are unaware of services available, and therefore do not inquire. These clients are dependent on Coos County Public Health staff to take the initiative and suggest services and opportunities that might be beneficial to them.

All Department programs are currently involved in providing information and making referrals to clients for services offered at the Health Department, as well as services of other agencies. The following are examples of common information and referrals provided by our department. The Family Planning Clinic provides options counseling to clients who become pregnant, and refers the client to the appropriate agency. The Healthy Communities Access Program and Oregon Mothers Care outreach specialist assists clients in applying for publicly funded health insurances, and in locating affordable primary healthcare services. WIC ensures that client's vaccinations are current by referring to the Coos County Public Health Immunization Clinic when scheduled immunizations are due. Home visiting nurses regularly refer parents of young children and pregnant women to free stop smoking classes offered by the local hospital.

### **Goals**

Coos County Public Health has the goal to assure those who qualify become connected with the many services available through public and private agencies designed to improve their quality of life. We plan to improve our already extensive referral program to provide even better, more prompt and complete information to members of our community. We want to see information of importance to the community passed on in the most effective way, to keep them informed and prepared in the case of an emergency, such as an outbreak of a communicable disease, a natural disaster or terrorist attack.

### **Activities**

To enable our staff to continue to improve their abilities to successfully refer our clients to other agencies for appropriate services:

- We will continue to invite individuals from other agencies, such as Red Cross and Child Welfare Services, to make presentations at our monthly all-staff meetings, so that our staff will become familiar with services provided by other agencies.
- We will participate in agency health fairs.
- New employee orientation will include an emphasis on the importance of our information and referral service, to ensure that new staff coming in will catch the vision of holistically meeting the needs of the community through interagency cooperation.

To facilitate the public's need to access accurate and pertinent information in a prompt manner:

- We will continue to strive to enhance our website to include more links to state and federal agencies, such as the CDC.
- We will continue to include our website address in all public information campaigns we make in other media, such as newspaper, radio or television.
- We will post health information and our department's services on our electronic sign.

- We will publish an annual report describing our services.

**Evaluation**

We will track who has attended the agency presentations made at our staff meetings. We will review orientation checklists to see that the proper emphasis on information and referral services has actually been included in all incoming staff orientations.

We will monitor our website with regularly scheduled inspections to track the condition and progress being made, checking for completeness and currency of the information. We will make needed adjustments or training to enable staff in our respective programs to update information relevant to their program. We will review all advertising to insure the website address is included.

## Licensed Facilities (& Other Institutions) – Action Plan 2007/2008

### Current Condition

Safety and prevention of illness are the goals for the Environmental Health Program for the 212 licensed temporary restaurants, 325 annually licensed facilities and 48 other inspected institutions operating within Coos County in 2006. Restaurants, public pools, bed and breakfasts, RV parks, overnight lodging, organization camps, schools, and child care centers are inspected and have education and consultation services available.

The Environmental Health Program benefits virtually every person residing in or traveling through Coos County. Consider the sheer numbers of meals served, nights stayed by RV campers and nights stayed in hotel/motels within Coos County at licensed facilities:

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**12,397** Seats in licensed Restaurants exist in Coos County.

If all of these seats are filled only 3 times a week that means:

**1,933,932** meals were served by Food Service establishments licensed and regulated by the Coos County Environmental Health Office.

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**1185** Sites licensed for overnight RV camping exist in Coos County.

If all of these sites were occupied only 3 nights a week that means

**184,860** nights of camping accommodation were provided by RV Parks licensed and regulated by the Coos County Environmental Health Office.

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**1101** Rooms licensed for Overnight Lodging exist in Coos County.

If all of these rooms were occupied solo for only 3 nights a week that means

**171,756** nights lodging were provided by Traveler's Accommodations licensed and inspected by the Coos County Environmental Health Office.

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Added together, on approximately **2.3 million** occasions, consumers in Coos County benefited from Environmental Health Services. The fact that in 2006 Coos County Public Health documented only 15 consumer complaints regarding all licensed establishments in Coos County, lends credibility to the idea of maintaining a proactive Environmental Health Services approach.

### Goals

Environmental Health Services provide education, consultation and inspection services to assure:

- Community visitors have clean safe traveler's accommodations
- Public pools and spas are free of disease causing germs
- Food workers know how to keep food safe
- Restaurants, schools and day cares serve safe food
- Day care facilities are free of environmental injury risks.

## Activities

- License and inspect food service facilities as required by OAR 333 Division 12. Inspection frequency may increase based on epidemiological risks.
- Provide Food Manager Certification Training
- Provide Food Handler Training at least twice monthly  
Provide Food Handler Training outreach in Bandon, Myrtle Point, and Coquille
- Follow-up on all allegations of food borne illness
- Initiate communicable disease epidemiological investigations of confirmed food borne illness outbreaks together with communicable disease nurses immediately upon notification
- License and inspect temporary food vendors
- License & inspect tourist accommodations for health and safety risks as required by OAR 333 Division 12
- License and inspect public pools for health and safety risks as required by OAR 333 Division 12
- Provide an annual Safe Pool Operator's Class
- Investigate complaints regarding legitimate environmental concerns at public pools relating to public safety and health
- Investigate complaints regarding legitimate environmental concerns relating to public safety and health at tourist accommodations

## Evaluation

The Licensed Facility Statistics Report provides a statistical evaluation for work done over the year. Prominent points from 2006 include:

<b>License Type</b>	<b>Inspections Performed</b>	<b>Closures</b>	<b>Misc. Consumer Complaints</b>
Public Pool	98%	5	0
Lodging	100%	0	1
RV Camp	100%	0	2
Food Service	110%	1	12

Food Complaints	11
Confirmed Food Borne Illness	0
Food Handler Training Cards Issued	628
Food Service Managers Certified	27

## **Safe Drinking Water – Action Plan 2007/2008**

### **Current Condition**

Everyone takes for granted the quality of Oregon's drinking water. But nationally, several water borne disease outbreaks have provided a reminder that drinking contaminated water can cause illness and even death. A keen interest in protecting drinking water has been renewed by the recognition that public water systems provide an easy conduit for a terrorist's threat into many homes. Our services provided in the Drinking Water Program are intended to assure good quality water.

Approximately 50,000 Coos County residents live where they are served by 74 known water systems. Most of the remaining 12,000 county residents (20%) live where they rely on private water supplies.

Among the 74 known water systems in Coos County, 43 are designated by EPA as public water systems and another 31 smaller water systems are defined by Oregon Revised Statutes as also being public water systems. It is noteworthy to recognize that federal funding exists to provide regulatory oversight for the EPA designated public water systems. But despite the fact that Oregon law requires the smaller public water systems to comply with similar standards as the EPA systems, no funding is made available to provide service to these smaller systems.

In practical terms, unless small state-designated systems voluntarily seek compliance, there is no appreciable difference when comparing them with private water sources, which have no regulation. No funding for oversight is available for non EPA water systems to assure that these water system users obtain good quality water.

County services provided for EPA designated Public Water Systems are covered in the Drinking Water Systems Assurances as per delegation agreement between Coos County Public Health and the State Drinking Water Program. This means the Environmental Health Program has direct responsibility to work with approximately 50% of the county's public water systems. The remnant of service is the responsibility of either the State Drinking Water Program office or the Oregon Department of Agriculture.

Environmental services are primarily directed toward helping public water system operators sort through a seemingly never ending maze of rules that relate to assuring the quality of the drinking water and may also include encouraging operators to take steps to physically protect the water and regularly sample, as required, for potential contaminants.

Though there are many potential contaminants for which water could be sampled, the following table provides examples of some contaminants with obvious health implications.

Contaminate	Examples		Implications
Chemical	Nitrates		Blue Baby Syndrome
	Trichloroethylene		Solvent linked to cancer, birth defects, reproductive problems
	Lead		Effects central nervous system and child development
Microbial	Bacteria	Escherichia coli O157:H7	Acute bloody diarrhea, abdominal cramps - occasionally leads to kidney failure
	Viruses	Hepatitis A	Fever, abdominal pain, fatigue, jaundice, loss of appetite, intermittent nausea, dark urine
	Parasites	Cryptosporidium	Symptoms include diarrhea, abdominal cramps, nausea, occasionally vomiting, low-grade fever

The potential for health problems from drinking water is illustrated by localized outbreaks of water borne disease. For example, in Oregon in 1993 and 1994, there were 30 renowned disease outbreaks associated with drinking water - 23 were associated with public water systems and 7 with private systems.

### Goals

Assure the availability of safe drinking water which is sufficiently free from biological, chemical, radiological, or physical impurities such that individuals will not be exposed to disease or harmful physiological effects.

**EPA Designated Public Water Systems:** Increase to at least 95% the percentage of people who receive a supply of drinking water from public water systems that meet all EPA health based safe drinking water standards.

**Non EPA Water Systems:** Direct water users to sources of information on practices to assure safe drinking water.

### County Activities

#### EPA Designated Public Water Systems

- Consult with system operators on steps to correct any water quality violations
- Work with system operators with water quality noncompliance and sampling issues
- Physically survey each water system no less often than every 5 years

#### Drinking Water Not Governed by EPA

- Refer users of private water to education sources such as OSU Extension.
- Refer small public water systems (informally known as “state regulated systems”) to the State’s Drinking Water Program
- Consult with suspected victims of water borne illness regarding ensuring drinking water safety as they are referred by Communicable Disease investigation staff.

**Evaluations:**

The following data tables represent work done in 2006 to ensure safe drinking water.

**Public Water Systems**

<b>Measure</b>	<b>Value</b>
<b>Number of consultations for water quality violations</b>	<b>6</b>
<b>Number of contacts to assist in correcting chronic noncompliance</b>	<b>12</b>
<b>Number of water system sanitary surveys conducted</b>	<b>5</b>
<b>Percentage of "EPA regulated" public water systems in compliance with water quality standards</b>	<b>63%</b>

**Drinking Water Systems Not Regulated by EPA**

<b>Measure</b>	<b>Value</b>
<b>Number of referrals</b>	<b>4</b>
<b>Investigations into suspected water borne illness complaints</b>	<b>0</b>
<b>Number of Water Borne Disease Outbreaks—confirmed</b>	<b>0</b>

**Action Plans**

**For**

**Other Public Health Concerns**

## **Public Health Emergency Preparedness – Action Plan 2006/2007**

### **Current Condition:**

Coos County Public Health (CCPH) continues to work towards coordination of emergency planning with our partners within the county, within Region 3 (Coos, Curry, Douglas, and Lane Counties), and the state. The Public Health Administrator continues to chair the local Health Emergency Response Team (HERT) that has met monthly since October 2001 for emergency response planning. The Administrator also participates on the Regional Preparedness Advisory Board, which coordinates the HRSA preparedness activities with hospitals and providers in Region 3, and with the Public Health Preparedness Leadership Team, which makes recommendations for the state's public health preparedness program. Due to staff attrition in 2005, a new Public Health Preparedness Coordinator (PHP) was hired and a new Public Information Officer was assigned to fill that role.

### **Accomplishments 05/06**

1. CCPH facilitated and participated in a functional exercise focusing on the inter/intra-agency emergency communication in a Pneumonic Plague event.
2. November 1, 2005 the BT Coordinator orientated the Public Health Staff to their incident command roles, prior to participating in the modified full-scale Pneumonic Plague exercise on November 2<sup>nd</sup>, 2005.
3. November 2<sup>nd</sup>, Coos County Public Health participated in the state and regional Pneumonic Plague interagency communications modified full-scale exercise.
4. In accordance with the Program Element #12, a Base Plan and a Natural Disaster Response Plan are currently being drafted.
5. The Mass Prophylaxis Plan, the Emergency Communications Plan, and the Strategic National Stockpile plan are currently being updated and modified.
6. Tribal representation has been included in our emergency planning work groups.
7. April 25<sup>th</sup>, 2006, the PHP Coordinator presented CCPH's Base Health and Medical Emergency Response Plan activation procedures to CCPH staff at a staff meeting.
8. April 25<sup>th</sup>, 2006, the PHP Coordinator facilitated an Emergency Communications Plan orientation and tabletop exercise to CCPH's Public Information Officer, Assistant PIO, Internal Communications Officer, and other Command Staff.

## Accomplishments 06/07

1. June 21, 2006, the Board of Commissioners approved the ESF #8, Health and Medical Annex for Coos County.
2. June, 2006, the PHP Coordinator began attending regular Oregon State DHS planning meetings for the PandORa Pandemic Influenza full-scale exercise.
3. August, 2006, the PHP Coordinator and PH Administrator began attending regular meetings and exercises to prepare for the possible Liquid Natural Gas facility on Jordan Cove in Coos Bay.
4. September, 2006, the PHP Coordinator created a Coos County PandORa Exercise Planning team comprised of local police, fire, hospitals, clinics, and emergency management.
5. September, 2006, the PHP Coordinator developed and presented section-specific ICS training for PH Staff.
6. October 11, 2006 the PHP Coordinator, PH Administrator and a Nurse from Coos Bay Schools facilitated a Pandemic Influenza Planning session to local school superintendent's, school board members, and school nurses.
7. November 1 and 2, 2006, Public Health participated in the statewide PandORa (Pandemic Influenza) exercise, collaborating with other county departments including Human Resources, County Board of Commissioners, Emergency Management, County Counsel, Sheriff's Office, and Road Dept. to staff all positions necessary to respond to a mass prophylaxis clinic. CC County Counsel and PH PIOs collaborated with local healthcare agencies and hospitals to facilitate a Joint Information Center to produce and disseminate cohesive information to the public during an emergency event.
8. December 2006, the PHP Coordinator and Administrator attended the statewide Public Health Preparedness Semi-annual conference.
9. January 2007, PHP Coordinator continues to develop and update public health emergency response plans, arrange for required ICS training based on individual emergency response roles, and develop and facilitate Pandemic Influenza Planning sessions to local city government with a focus on business continuity. The PHP Coordinator has begun attending an exercise planning meeting for a functional earthquake exercise in June 2007.

## **Response Capability**

We currently have a staff of nurses and an environmental health specialist (EHS) trained in CD 101 and CD 303 to increase the ability of our department to respond to an outbreak/incident. This has also increased the number of individuals available to be on-call 24/7 for reporting purposes.

We continue to follow our policies and procedures for 24/7 reporting. The pager number for emergencies is available to the public on our answering machine and has been distributed to the local care providers, hospitals, ambulance services, fire & police departments, and veterinarians. We continue to provide a direct phone line into the desk of one of the Public Health Nurses. When the pager is being carried after regular hours by any of the nurses who do not normally provide communicable disease response, then one of the regular CD nurses is available by pager and/or telephone to back them up.

## **Training Opportunities**

In September of 2005, the PHP coordinator attended a Weapons of Mass Destruction training. In November, our department participated in the full-scale exercise. The PHP Coordinator attended several online trainings including the updates on Influenza and SARS, and continues to participate in public health preparedness online trainings. The PHP coordinator continues to attend the OREpi conferences and trainings offered by the state, to stay up to date with preparedness for new and existing diseases and public health threats.

In January, the new back-up Public Information Officer attended the PIO Crisis and Emergency Risk Communication Course in Roseburg.

All staff have been trained in ICS 100, NIMS 700, and have been oriented to their roles in a public health emergency.

## **Goals:**

- To be prepared to respond to reports of unusual events, either man-made or naturally occurring, in an efficient and organized manner.
- To provide education to the community on how they can best protect themselves from both known and emerging diseases or from an act of willful destruction to health or property, such as use of a weapon of mass destruction (WMD) or an act of bioterrorism (BT).
- To continue to participate in the ongoing revision of our County Emergency Operations Planning to ensure that Public Health is prepared to respond to incidents in a coordinated manner with our county government, and with our community and state partners.
- To continue to improve communications between local emergency 1<sup>st</sup> responder agencies, local healthcare agencies, regional partners, and state partners to effectively respond to an emergency event while keeping the public safe and informed with up-to-date information
- To continue to develop relationships with businesses, schools, faith-based organizations, tribal agencies, social service agencies, and other community members to facilitate community-wide public health emergency preparedness and response.

### **Activities for 06-07:**

- Continue to provide 24/7 access to nurses trained in communicable disease for those in the local health system, first responders, and Oregon State Public Health.
- Develop and update procedures for mobile CD investigation response teams, CD case investigation, response, and reporting (for diseases such as smallpox, pandemic influenza, and tuberculosis), quarantine, isolation, and restriction of movement, and procedures for surge capacity of paid and volunteer staff during a public health emergency event.
- Update emergency planning for medical response annually, and integrate the medical response procedures into the Coos County Emergency Operations Plan.
- Update the county website with pertinent information on communicable diseases and/or public health preparedness topics.
- Continue to facilitate the local Health Emergency Response Team meetings, monthly.
- Provide continuing education to the Public Health staff on potential duties and/or responsibilities during a communicable disease outbreak, BT incident, and/or natural disaster health recovery.
- Encourage participation by our local tribal officials, schools, faith-based organizations and social service agencies in planning for incidents regarding communicable disease and/or other public health emergencies and bioterrorist events.
- Continue to test current communication capabilities, including alternate communication devices, with all local partners to ensure ability to distribute information during emergency situations.
- Complete the staff training on respiratory protection and fit testing.
- Participate in regional and statewide exercises (including a point of distribution clinic for mass prophylaxis).
- Complete and update the necessary public health emergency response and health recovery plans (such as the ESF #8 Health and Medical Annex, Emergency Communications Plan, SNS and Mass Prophylaxis plan and Natural Disaster Health Recovery Plan), annexes and attachments, with a focus on pandemic flu.
- Continue to work with law enforcement, hospitals, health care agencies, emergency management, local businesses, other government agencies, and other client-services based agencies to address needs of vulnerable populations during an emergency event.
- Work with local businesses and schools to facilitate the preparation of emergency response health plans, with an emphasis on pandemic flu response.
- Work with local businesses and emergency response agencies on development and review of current emergency response plans and procedures for a possible Liquid Natural Gas facility.
- Continue to participate in all monthly LHD Public Health Preparedness conference calls, as required.
- Continue to perform semi-annual reporting in the Public Health Preparedness Program.

### **Evaluation**

Evaluation of our progress will be done quarterly using the assurances provided by program element 12 of the IGA with DHS-State Public Health. Records of activities will be maintained.

### **Challenges**

The contractual expectations in this program are challenging and exceed what is funded.

## HIV Client Services – Action Plan 2006/07

### Current condition or problem:

According to the most current State reports, there was 1 new case of AIDS reported in Coos County in 2005. Estimates indicate that there may be 60 individuals with HIV/AIDS currently living in Coos County. Coos County Public Health has recently been serving 24 clients, in the Ryan White case management program, with several additional intakes recently.

People living with HIV/AIDS (PLWHA) face multiple challenges. Employment is difficult, access to support services can be confusing, maintaining a complex prescription regimen for years is frustrating, and the psychological shift from productive citizen to patient on a long slow death spiral causes many to suffer from depression. Social stigmatization continues to isolate PLWHA. The dementia that HIV causes leaves many people unable to understand the forms and procedures required to access services.

Existing barriers to the access of life saving prescriptions continue to be problematic. Budget shortfalls have eliminated programs that provide necessary medications. The highly touted Patient Assistance Programs offered by drug manufactures are time consuming, confusing, and labor intensive. The federally funded Aids Drug Assistance Program is not the panacea needed to ensure prescription coverage for PLWHA.

Poverty caused by job loss and disability coupled with social misconceptions make independent living problematical for HIV infected people.

### Goals

The goals of Coos County Public Health's Ryan White Title II case management program are to provide a comprehensive continuum of primary care and supportive services that promote the mental, physical, and social well being of PLWHA

### Activities

Psychosocial case management services:

Client identification and outreach: The Ryan White case manager shall collaborate with local outpatient medical clinics informing practitioners of the scope of services available to PLWHA. The Ryan White case manager will encourage word of mouth communication about local Ryan White services from existing clients to others who may benefit from Ryan White services.

Assessment: The Ryan White case manager will conduct a one on one discussion with the client at least annually (more often if necessary), about their goals and objectives, presenting problems or issues. The client and the case manager will complete a written care plan that lists prioritized issues and problems to be addressed. This written care plan will provide a framework for both the case manager and the client. A designated staff R.N. will monitor disease status and progression and will conduct routine health assessments.

Planning: Agreement through discussion shall occur between the client and the case manager, assigning responsibility for completion of each task listed in the care plan. Timelines and specific activities may be used as a guide. The case manager will broker services for the client as needed, and provide assistance to the client as needed in filling out forms and advocating for services. Authorizations of RW funds by the case manager shall be made to assist the client with unforeseen emergencies that may otherwise compromise the client's access to routine medical care and disrupt their day-to-day stability.

Monitoring: Monitoring the RW case load will occur to ensure that the case manager is aware of changes of client health status and obstacles faced by the client that hinder his or her ability to function in a maximally independent capacity in the community. The case manager, with input from the client, shall determine the degree to which a client shall be monitored. The client's level of acuity (or ability to function independently in many facets of daily living) may also determine the level of monitoring to be done. Monitoring will consist of telephone contact, Public Health office visit, home visit or contact in other community-based settings. Reassessment, care plan revision and modification occurs semi-annually, annually or as needed.

Additional Functions The case manager will provide ongoing documentation in the client file of all contacts, actions, authorizations or other pertinent information that promotes continuity of care. Other activities identified as being provided on an as-need basis include direct service (assistance with obtaining food for example), group education and socialization activities, crisis intervention, system advocacy, resource development and discharge planning.

### **Evaluation:**

Measurement of meeting the above-mentioned objectives occurs in several ways:

- Clients are asked periodically to evaluate the level of services they receive. They are encouraged to point out any shortcomings or obstacles that they have faced.
- Routine chart reviews are done to ensure that the most current information is available and that all necessary forms are in place. This will facilitate accessing necessary resources and services.
- Care plans are reviewed periodically. As client goals are achieved, the issue is eliminated. Success can be measured in terms of goals accomplished and to a greater extent, when they are accomplished within the timelines stated.
- Clinical and psychosocial outcomes are measured by using the acuity scale provided by the Department of Health Services. The scale ranges from 1 (independent) to 4 (dependent). Movement among the scale is indicative of client progress or regression.

### **Challenges:**

Through implementation of the federal Ryan White grant, we have been instrumental in meeting the diverse needs of persons with HIV disease in our community. Our greatest challenge this past year has been staff attrition. In order to meet the training requirements, staff must travel to Salem or Portland, which is a financial burden on our department.

### **Accomplishments:**

- Client files are routinely reviewed to facilitate the provision of timely psychosocial and clinical case management services.
- The transition to the new Medicare part D program was completed for clients who qualified prior to the May 16, 2006 deadline.
- Increased utilization on local services, such as food boxes, and fraternal organizations (such as the Lions Club for vision and hearing aids) occurred, reducing the fiscal burden on the local Ryan White program.
- The local Ryan Program is the privileged benefactor of charitable contributions of a local church that donated approximately \$200 to client services.

## Unmet Needs 2007/08

The unmet needs are generally the same as have been discussed the past two years. The health issues that receive our focus and action continue to be the ones that have a funding stream. Our discretionary funds continue to be extremely limited. The *State Support for Public Health* per capita allotment for our county remains static at about 59 cents per person per year. Our county's general fund support was less than 10% in 2005/06, increased to 21% in 2006/07, and is now projected to be less than 5%. An increase in the *State Support for Public Health* per capita will be critical for our department to adequately fund the communicable disease and TB case management program elements. State funding for the TB case management at less than \$800 per year does not begin to pay for the investigation and case management of latent or active cases.

The primary causes of death in our county are cardiovascular disease and cancer, and both cancer and cardiovascular disease are related to the high use of tobacco that we have locally. During 1999-2003, the age adjusted rate showed that Coos County ranked 3<sup>rd</sup> highest in the state for *high incidence* cancers (an improvement), although Coos continues to have the highest death rate in the state for lung cancer. Also, our rates for obesity are higher than the state rates. We have been fortunate to receive some state funds for the resumption of a tobacco prevention project this past year. We were unsuccessful in competing for some of the limited federal funds offered by the state for a diabetes/asthma/ cardiovascular disease project. Otherwise, we have no funding to address this need.

Although our teen pregnancy rate has steadily decreased over the past few years, we are seeing a reverse trend in the latest statistics. Our cases of sexually transmitted diseases have been consistently high, and funds to educate teens about safer sex practices are limited. We are receiving a small increase in our HIV prevention funds provided by the state, although it does not go far.

Public Health Nurse Home Visitation continues to be a much needed program in Coos County, and we are achieving positive outcomes in preventing child abuse in the families we serve. Although research has proven that **nurse** home visitation is the most effective type of home visiting to high risk clients, this model continues to lack financial support statewide. It is a challenge to provide a strong public health home visiting program, which is very much sought after by clients, agencies, hospitals, and the medical community, with limited funds. Our nurse home visiting program is built on the infrastructure of Medicaid billing, funding that is based on decisions at the federal level. An increase in the Medicaid reimbursement rates specific for the maternity case management (MCM) program, or an alternative source of funding, would help to cover the cost of providing the MCM service. Providing intervention during the prenatal and early postpartum period is very cost effective way of preventing problems with a very high risk population.

Oral health care remains a challenge in the maternal child health program. Our nurses have been diligent in assessing and referring pregnant women and young children to dentists for exams and treatment as recommended by the Early Childhood Cavities Prevention program, sponsored both by DHS and OMAP. We continue to receive concerns from parents that dentists are not

accepting their young children at the ages that are recommended. Our field services staff have had several summit meetings with representatives from the local dental plans and community partners, and some progress is being made.

And finally, we continue to recognize that there are many more individuals and families who are now ineligible for the Oregon Health Plan, and are essentially without health care. Our efforts to assist our constituents in their quest for affordable health care have become more challenging than ever.

## **Budget Statement**

Contact to receive a copy of our approved budget document:

Sherrill Lorenzo  
Business Operations Manager  
Coos County Public Health  
541-756-2020, ext. 539  
slorenzo@co.coos.or.us

**Comprehensive Plan Statement**  
Senate Bill 555

The Coos County Board of Commissioners, who are the Local Public Health Authority, also oversee the Coos County Commission on Children and Families, which was responsible for coordinating the comprehensive planning process in Coos County.

Health Department staff have participated in the most recent update to the comprehensive plan. Annual plan topics which are also included in the comprehensive plan include: prenatal care, immunizations, child abuse, use of alcohol, tobacco and other drugs, and teen pregnancy.

## VII. Minimum Standards -- Coos County Public Health

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. (There is not a single manual for all forms.)
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. (Only as needed.)

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, or more frequently based on epidemiological risk.
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. (DEQ)
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. **(by DEQ)**
- 64.** Yes  No  The health and safety of the public is being protected through hazardous incidence investigation and response. **(by DEQ)**
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. (other agencies contribute to regulation)
66. Yes  No  All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448. (Added per G.S. request, not in program indicators)

### **Health Education and Health Promotion**

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

### **Nutrition**

73. Yes  No  Local health department reviews population data to promote appropriate nutritional services.
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 (n/a)
75. Yes  No  Clients identified at nutritional risk are provided with or referred for appropriate interventions.
76. Yes  No  Culturally and linguistically appropriate nutritional education and promotion materials and methods are integrated within programs.
77. Yes  No  Local health department supports continuing education and training of staff to provide effective nutritional education.

### **Older Adult Health**

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

### **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**

- 103.** Yes  No  The local health department Health Administrator meets minimum qualifications: **The Administrator has a bachelor's degree in community health and 20 years of public health experience, including 11 years in public health management.**

A Master's degree from an accredited college or university in public health, health administration, public administration, behavioral, social or health science, or related field, plus two years of related experience.

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

104. 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.

105. 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.

106. 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.

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

John Griffith  
Local Public Health Authority

Coos  
County

Feb. 7, 2007  
Date

# Coos County Public Health

## Organizational Chart

