Douglas County
Health and Social Services Department

May 1, 2008

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

Dear Mr. Engle:

Enclosed please find Douglas County's Public Health Annual Plan for 2008/2009, which is being submitted pursuant to ORS 431.385. This plan has been prepared according to your instructions and assures that the activities defined in ORS 431.375 - 431.385 and ORS 431.416 are performed. If you have any questions or need further information, please contact me at (541) 440-3625.

Douglas County submits this Annual Plan with the understanding that various staff, programs, and plans will be evolving or be eliminated to match state and federal funding available come July 1, 2008. At this time we are planning to provide public health services as outlined in this annual plan. We will continue to work with CHLO on how to provide public health services with limited funding.

Sincerely,

Peggy Kennerly, Public Health Division Administrator
Douglas County Health and Social Services

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I. EXECUTIVE SUMMARY

Douglas County Health and Social Services (DCHSS) exists for the common good and is responsible for leadership in the promotion of social, economic and environmental conditions that improve health and well-being and prevent illness, disease and injury. Accordingly, DCHSS defines itself around the nationally recognized Ten Essential Public Health Services, which describe what every person, regardless of where they live, can reasonably expect their Local Public Health Authority to provide. DCHSS strives to provide the following essential public health services.

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

Because of the rural demographics, Douglas County provides these essential public health services with additional or different approaches than an urban county. In addition, there are public health concerns that are unaddressed due to competing priorities and fiscal shortfalls. Also in comparison to statewide, Douglas County faces the challenges of an aging population, higher rate of unemployment,, higher poverty rate, fewer educational opportunities, increased substance abuse, and fewer resources to help address these challenges. The scarcity of health care coverage and the concentration of providers in the County's central core area are exacerbated by limited public transportation, longer travel distances to health care services, and limited access to health care specialists.

The most difficult obstacle in providing public health services is inadequate funding. County public health programs have historically relied on federal funding. For 2008-2009, Douglas County is planning for a year without receipt of new federal timber safety net funding. The County Board of Commissioners has directed the Public Health Division to cut approximately $300,000 from the Public Health Division budget. With less county general fund dollars, the health department will rely more on state funding, grant monies, Medicaid-match programs, and revenue from service provided. There is no local property tax funding to support public health. Douglas County government

continues to evaluate plans on how to increase revenue, streamline programs, and cut non-essential services.

Douglas County submits this Annual Plan with the understanding that various staff, programs, and plans will be evolving or be eliminated to match state and federal funding available on July 1, 2008. The Health Department will continue to work with CHLO on how to provide public health services without adequate funding.

II. ASSESSMENT

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

Geography

Douglas County extends west to east from sea level at the Pacific Ocean to 9,182-foot Mt. Thielsen in the Cascade Range. Douglas County covers an expansive 5,071 square miles, just larger than the state of Connecticut. The county contains nearly 2.8 million acres of commercial forest lands and one of the largest stands of old growth timber in the world. Over 50 percent of the land area of the county is owned by the federal government (Oregon Blue Book 2007).

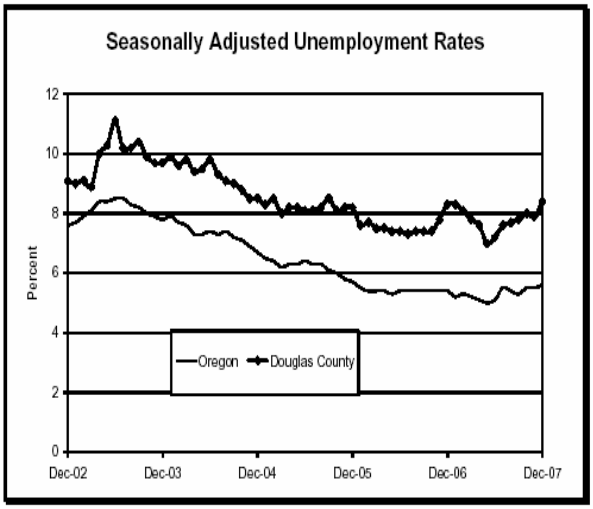
Population

Douglas County's population has grown to 104,675; a 4.3% estimated increase since the April 2000 census (July 2007 Population Research Center Certified Estimate). Forecasts of Oregon's county populations, predicts that Douglas County will have a population of 140,619 at year 2040. The median age of Douglas County residents is slightly older at 43.4 years of age in 2006, as compared to 36.4 years of age statewide (2006 American Community Survey data). Douglas County's population ages 65 and older makes up 18.4% of the county population as compare to 12.5% statewide (July 2007 Population Research Center Certified Estimate). Overall, Douglas County's population is predominately white (92.7%), compared to 90.5% statewide. Douglas County's Hispanic population has increased from 2.4% in 1990 to 4.0% in US Census 2006 American Community Survey data.

Income and Poverty

US Census 2006 American Community Survey data show that 16.0% of Douglas County individuals are at or below the Federal Poverty Level, as compared to 13.3% statewide. Data from the 2007 Children First for Oregon report show that approximately 25.2% of children in Douglas County live in families that are at or near the poverty level, compared to 16.8% statewide. The 2007 data reflects a worsening rate compared to the 2006 Children First for Oregon report showing that 22.2% of children in Douglas County live in families that are at or near the poverty level, compared to 18.4% statewide.

The economic difficulty faced by many Douglas County families is further reflected in local income and poverty data. The median household income in Douglas County is $45,700, which is 18% lower than the state median (Children First for Oregon 2007). In addition, Douglas County's unemployment rate in January 2008 was 9.9%, the fourth highest in Oregon, as compared to 5.5% statewide (Oregon Employment Department, OMLIS 2008). Also according to the Children First for Oregon 2007, 45.6% of Douglas County children were eligible for free/reduced price lunches during the school year, as compared with 42.1% statewide.



Alcohol, Tobacco, and other Drug Use

Alcohol, tobacco and other drug use affects families, schools, workplaces, and entire communities. On almost all measures, rates of alcohol, tobacco and other drug use are higher among Douglas County youth and adults than among youth and adults statewide. In 2006, 36% of 8th graders and 50% of 11th graders reported drinking alcohol on one or more occasions in the past 30 days (DHS Addictions & Mental Health Report, 2008). Of those who report drinking, 18% of eighth graders and 32% of 11th graders reported binge drinking (5 or more drinks in a row in a couple of hours). In 2006, rates of marijuana use by Douglas County youth were 13% for 8th graders and 21% for 11th graders.

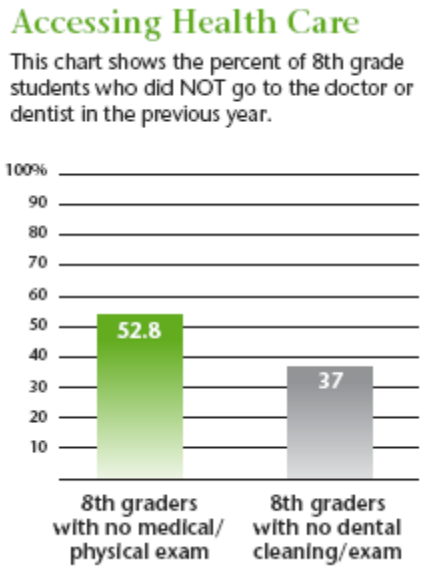
Douglas County adults smoke at a higher rate (27%) than adults statewide (20%) (DHS Tobacco Facts, 2007). Among youth, 15.1% of 8th grade students and 21.7% of 11th grade students report current smoking. Nearly one in four women (23.9%) in Douglas County report using tobacco during pregnancy, as compared to 12.3% statewide (DHS Tobacco Facts, 2007). Tobacco costs Douglas County residents nearly $98.9 million per year in direct medical costs and indirect costs due to lost productivity due to tobacco-related deaths (DHS Tobacco Facts, 2007).

Physical Activity, Diet, and Obesity

Data show that 28.9% of 8th graders and 25.5% of 11th graders in Douglas County are overweight or at risk for overweight, as compared to 25.8% and 24.9% respectively statewide (Oregon Healthy Teen Survey, 2005-2006). Only 22.1% of 8th grade students and 17.5% of 11th grade students eats the recommended 5-a-day fruits and vegetables, as compared to 25.3% and 20.3% statewide. Moreover, 64% of adults are overweight or obese, as compared to 59% statewide (Keeping Oregonians Healthy, 2007).

Health Care Coverage

Rural Oregonians continue to be less well-served than those who live in metropolitan areas. In 2005, the Portland area (Multnomah, Clackamas and Washington counties, had 311 physicians per 100,000 population, while the rural counties of southwest Oregon had only 206 physicians per 100,000 population. In addition, Douglas County in 2006 reports 1.82 active physicians per 1,000 population, compared to a statewide average of 1.49 active physicians per 1,000 population (Oregon Office of Rural Health). Data show that 10.1% of children in Douglas County have no health insurance, as compared to 12.6% statewide (Children First for Oregon, 2007).



Safety net medical services are evident in the community; a Federally Qualified Health Center (FQHC) is located in Roseburg with a well-established satellite clinic in Glide. The FQHC established a new satellite clinic in Drain in February 2007 and started a capital campaign in April 2007 to establish a satellite clinic in South County. Also in 2007, the FQHC became a delegate agency under the County's Immunization Program, which opened up free vaccine to 317 eligible clients at the FQHC and opened up free vaccine to the underinsured VFC eligible clients seen at the county health department.

Douglas County has three hospitals within its borders; the Roseburg Veteran's Affairs Medical Center, Mercy Medical Center, and Lower Umpqua Hospital. Mercy Medical Center closed the doors to its Behavioral Health Unit (BHU) in late October 2007, leaving Douglas County patients and families without local acute mental health hospitalization. The hospital closed the unit because it reported losing more than $2 million annually. In the wake of the BHU closure, the hospital's emergency department added two treatment rooms, for a total of three rooms, which are designated for mental health patients. There patients can receive preliminary evaluations and develop a future plan for care. The Crossroads treatment facility, operated by Adapt, opened six beds, for people needing sub-acute mental health care and treatment for an alcohol or drug problems. As of April 2008, a private mental health company is in negotiations to begin providing a 16 acute care bed mental health facility.

Chronic Disease

Chronic diseases are the major causes of disability and death for Oregonians. Cancer is the leading cause of death in Douglas County, followed by heart disease, and then cerebrovascular disease and chronic lower respiratory disease. The incidence rates of the leading chronic diseases in Oregon are consistently higher in Douglas County, as compared to the state overall (Oregon Vital Statistics 2005). There are a number of

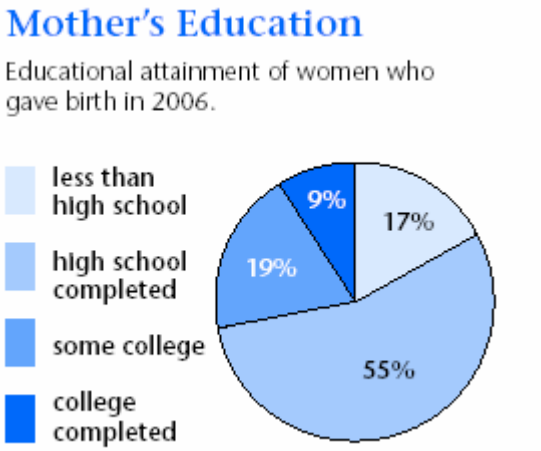
modifiable risk factors that contribute to the higher incidence of chronic disease in Douglas County, including higher rates of tobacco use, physical inactivity, and poor nutrition. In addition, higher poverty rates, low level of education, the lack of health insurance, limited access to health care, and the County's older population all increase the risk of chronic disease in Douglas County.

Oral Health

Oral health care is simply out of reach for many uninsured and underinsured children and adults in Douglas County. Consequently, many are at an increased risk for periodontal infection, tooth loss, and more serious health problems that result from or co-occur with dental disease. According to the Oregon Smile Survey of 2007 nearly two in three (64%) children in first, second, and third grades have already had a cavity. In Douglas County this number increases to 78% by the time students reach the 8th grade (Oregon Health Teens Survey, 2005-2006). In January and February 2008, DCHSS conducted a brief phone survey of fourteen Douglas County preschools and found that only one of the fourteen provides dental education as part of their daily program activity.

In September 2005, Douglas County was re-designated by the Health Resources & Services Administration (HRSA), Bureau of Health Professions as a dental health care shortage area. The ratio of population to dentist is 10,457:1 and contiguous county resources are inaccessible or excessively distant. Community water fluoridation is one of the safest, least expensive, most effective and simplest ways to fight tooth decay. Oregon ranks 48th out of 50 states for water fluoridation. Douglas County does not have community water fluoridation. The Public Health Division supports the fluoridation of community water supplies to reduce tooth decay.

Youth Development and Education



Eighth grade reading proficiency is at a rate 4% worse than compared to reading proficiency statewide, as well as the eighth grade math proficiency is at a rate 12% worse than compared to statewide math proficiency (Children First for Oregon 2007). Approximately 14.6% of Douglas County residents 25 years of age and older have not graduated from high school, as compared to 12.4% statewide. Only 14.2% of Douglas County residents hold a Bachelor's degree or higher, as compared to 27.5% statewide (US Census 2006 American Community Survey). In addition, 72% of babies in Douglas County are born to mothers with a high school education or less, as compared to 51% statewide. Education is closely tied with youth development and crime. Douglas County's juvenile arrests is at a rate 61% worse than compared to juvenile arrests statewide (Children First for Oregon 2007).

Maternal and Child Health

Teen pregnancy rates in Douglas County are 8.3/1,000 births to teens ages 10-17 compared to statewide at 8.8/1,000 births to teens ages 10-17 (DHS, Centers for Health Statistics, 2007). While teen pregnancy rates have declined in Douglas County and Oregon over the last years, other maternal and child health indicators are of concern in Douglas County. The rate of low birth weight babies in Douglas County in 2006 was 70.7/1,000 births, as compared to 61.0/1,000 births statewide (Oregon Vital Statistics 2006). Nearly one in four women (23.9%) in Douglas County report using tobacco during pregnancy, as compared to 12.4% statewide (DHS, Tobacco Facts, 2007).

Abuse and Neglect

In Douglas County in 2007, 138 children were victims of child abuse/neglect (6.1 per 1,000 children), which is a rate similar compared to Oregon's 7.6 per 1,000. Forty-nine percent of victims of abuse/neglect are under age six, as compared to 55% statewide. 463 children in the county have been in foster care at least once during the past year, with 16.8% of these children in foster care not having stable placement (Children First for Oregon 2007).

Local Health Department Basic Services

The mission of DCHSS is to assist residents and visitors in Douglas County to be healthy, independent, and safe. DCHSS administers and enforces state and local public health rules and laws. In addition, DCHSS assures activities necessary for the preservation of health or prevention of disease.

DCHSS provides the five basic services contained in statue (ORS 431.416) and rules. These duties and functions are performed in a manner consistent with Minimum Standards for Local Health Departments, adopted by the Conference of Local Health Officials (CHLO).

It is important to point out that inadequate funding to Public Health continues negatively impact on our ability to provide both basic and other public health services. In fiscal year 2004-2005, the Public Health Division had a budget that supported 64.7 FTE. In fiscal year 2008-2009, the Public Health Division will have an expected staffing of 49.8 FTE. With a reduction in staff comes a reduction in services, reduction in revenue, and a reduction in matching funds. The Public Health Division is cutting approximately $300,000 from its 2008-2009 budget. A cut of this magnitude has had and will continue to have a far-reaching impact on all Public Health Programs and the health of our community.

Adequacy of Core Services

1. Epidemiology and control of preventable diseases and disorders:

   Emergency preparedness funding and an increase in State Support for Public Health dollars, has allowed Public Health to dedicate a Public Health Nurse to communicable disease reporting and investigation. This support has enhanced the timeliness of disease reporting, increased our capacity to conduct disease investigations, provided for additional outreach efforts to address disease outbreaks and Hepatitis C, has built an employee immunization program, and has increased our ability to implement quality assurance procedures. Public Health is able to address epidemiology and control of preventable diseases; however, additional funding and staffing is recommended to adequately address public health priorities and meet national and state benchmarks. Additional funding and staffing would allow for a strengthened program, including but not limited to more than the minimal investigation of Hepatitis C; a strengthened Immunization Program that could be more proactive with community immunization providers; and the ability to analyze disease data by a health disparity or geographical location. It is difficult to sustain a minimally adequate response to epidemiology and control of preventable diseases when State funding has been reduced or is unpredictable, and County Public Health Programs rely on grant funding and County general fund dollars. For example, in 2008-2009 funding specific to Preparedness is again being reduced; in 2006-2007 Douglas County received State funding of $135, 668 and split that between the Preparedness Coordinator position and the Public Health Communicable Disease Program. In 2008-2009 state Preparedness funding will be $113,567 and the Public Health Communicable Disease Program will receive only $16,324 of this. In addition, Douglas County Public Health will receive no State funding specific to control of Sexually Transmitted Diseases, only in-kind donations of medications. In addition, HIV funding from the State is unpredictable with Oregon counties coming on or off the funding formula from year to year, making it difficult to plan for long term goals and sustainable activities. The State funding for Tuberculosis is $1,312 in Douglas County; not enough to fund the activities to investigate one case of active Tuberculosis. Although the State Support for Public Health dollars doubled in the 2007 legislature to now provide Douglas County with $121,005; this money does not go far when divided between the County's Communicable Disease, HIV, STD, TB, and Environmental Health Programs.

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

   Funding cuts to Public Health in the 2008-2009 budget mean the elimination of 1 Healthy Start position, 2 field staff nurse positions, 1 family planning nurse practitioner, 1 clinic support person, reduction in the Students Today Aren't Ready for Sex (STARS) staffing, reduction in staffing dedicated to health education and population based-services, and the closure of the Public Health Prenatal Clinic.

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

The loss of funding for the coordination of the STARS program and Healthy Teens Coalition will have a negative impact on pregnancy prevention education to Douglas County middle schools and curtail county-wide adolescent health promotion.

Closing the Public Health Prenatal Clinic will mean a loss of prenatal services to approximately 300 low-income women, and fewer referrals to other Public Health programs such as Maternity Case Management and WIC, thus reducing revenue to the Maternity Case Management Program.

3. Collection and reporting of health statistics;

   Birth and death reporting, recording, and registration are provided by the DCHSS Roseburg office. Due to the geographic size of Douglas County, the outlying offices in Canyonville and Drain provide completed and registered birth certificates to customers. In 2006, DCHSS implemented electronic death registration but full implementation has yet to occur. Only one county physician participates in electronic death registration. DCHSS implemented electronic birth certificates in January 2008.

4. Health information and referral services;

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

5. Environmental health services..

   The Environmental Health Division has been moved from a Division to a Program level within the Public Health Division. This changed supervision to the Public Health Division Director. A Program Supervisor was assigned within the Environmental Health Program. In 2007-2008 fees were changed for Temporary Food Service Licenses. This change required operators to register 3 working days prior to an event or pay a late fee. An evaluation of the Environmental Health fee structure is currently being conducted. Program fees are expected to increase significantly in 2008-2009 due to the expected loss of the federal timber safety net dollars. No fee adjustments have been made since 2004.

Adequacy of Other Public Health Services

The Douglas County Public Health Division has, in the past, provided a number of services of importance to the health of Douglas County, including health education and promotion, dental health, older adult health education, and other important public health services. Budget cuts to the Public Health Division in fiscal year 2008-2009 reduce our capacity to provide many of the programs and services that promote the health of our community. The following describes the other services provided under OAR 333-014-0050 during fiscal year 2008-2009.

1. Emergency preparedness including participation in the development of the county's emergency response plans and internal procedures necessary to carry out the local health department role in the plans;
    (i) Douglas County Public Health reviews plans written by the DCHSS Preparedness Coordinator to ensure coordination with Public Health resources and plans. Douglas County Public Health employees are trained in ICS 100 and 700; staff is trained in higher level Incident Command courses as appropriate. Douglas County Public Health participates in countywide preparedness exercises. The Public Health Education Program staff has received advanced training to fulfill the role of the local health department Public Information Officer. With cuts to the Public Health Division in fiscal year 2008-2009, this responsibility will be significantly reduced and/or shifted to another Division.

2. Laboratory services including providing diagnostic and screening tests to support public health services which are in compliance with quality assurance guidelines established by the State Health Division
    (i) Douglas County Public Health has lab services that provide supportive services primarily to the Family Planning, WIC, and HIV/STD clinics. The lab is a moderate, high complexity Clinical Laboratory Improvement Amendments certified lab, authorized to perform bacterial, mycological, & parasitological testing.

3. Health education/health promotion including activities and programs to promote health and assist individuals and groups to achieve and maintain healthy behaviors;
    (i) Budget cuts to the Public Health Division in fiscal year 2008-2009, reduce our capacity to provide population-based health education. Health education provided by the Public Health Education Program, will be limited to the implementation of the tobacco prevention and education grant program. Limited child safety passenger seat education will be provided, but at a greatly reduced level than in past years. Budget cuts to Public Health in fiscal year 2008-2009 mean the elimination of the following population-based services and activities (except as related to tobacco prevention): physical activity and nutrition activities; oral health promotion; child injury prevention; worksite wellness; community needs assessments; capacity building and community resource coordination; implementation of

health promotion programs to targeted audiences; grant writing and contract management; coordination of media campaigns; policy development; and coordination of other special projects. It should be noted that basic client-based health education will be provided to individuals/families who receive services through the various Public Health Division programs (e.g., Nurse Home Visit, WIC, and Family Planning).

4. Epidemiological investigation of deaths of public health significance with the county's medical examiner's office;
    (i) The medical examiner notifies Public Health of deaths of public health significance.

5. Nutrition services including identification and intervention with client's at nutritional risk, and education and consultation for the promotion of good dietary habits;
    (i) Nutrition services are provided by the WIC Program. Nutritional assessment and education pieces are included within Maternity Case Management, Babies First!, Tuberculosis Program, HIV Case Management, CaCoon, and other Public Health programs.

The following areas listed in OAR 333-014-0050 will not be supported with staffing, planning, or resources in fiscal year 2008-2009: dental health, health education/health promotion (except as it relates to tobacco prevention), older adult health education, and primary health care services.

III. ACTION PLAN

Action plans are included for:

1. Epidemiology and Control of Communicable Diseases
2. Emergency Preparedness
3. HIV
4. STD
5. Tuberculosis
6. West Nile Virus
7. WIC
8. Family Planning
9. Perinatal Health
10. Child Health
11. Adolescent Health
12. Immunizations
13. Oral Health
14. Nutrition and Physical Activity
15. Substance Abuse
16. Child Injury Prevention
17. Health statistics
18. Health information and referral services
19. Environmental health
20. Water

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

a. Current condition

DCHSS is mandated by Oregon law to "use all reasonable means to investigate in a timely manner all reports of reportable diseases, infections, or conditions (OAR 333-019-0000). With regard to public health emergency preparedness, Douglas County has taken steps to ensure timely detection, response, and efficiency in communicable disease reporting. State support for public health dollars were doubled in 2007-2008, which awarded Douglas County $121,000 versus the previous award of $60,600. The increased state support for public health dollars is not even sufficient to fund two nurses and because local public health relies on state funding streams that have remained static over the years, or have even decreased or disappeared, the state support for public health dollars have been spread to HIV, STD, TB, Communicable Disease, and Environmental Health programs in order to preserve public health functions. A separate funding stream, the federal funds for public health preparedness which started after September 11th, have helped our department to respond to communicable disease outbreaks as well as support critical emergency response planning; however, these funds have also been decreasing, except for the special federal award directed solely towards pandemic influenza preparedness.

It is difficult to sustain a minimally adequate response to epidemiology and control of preventable diseases when State funding has been reduced or is unpredictable, and County Public Health Programs rely on grant funding and County general fund dollars. For example, in 2008-2009 funding specific to Preparedness is again being reduced; in 2006-2007 Douglas County received State funding of $135, 668 and split that between the Preparedness Coordinator position and the Public Health Communicable Disease Program. In 2008-2009 state Preparedness funding will be $113,567 and the Public Health Communicable Disease Program will receive only $16,324 of this.

DCHSS strives to improve the timeliness of communicable disease case reporting to DHS. In 2006, Douglas County ranked 19th among 32 counties, with 98.3% of case reports arriving at DHS within 12 days from receipt of report. These numbers are far better than the pre-September 11th era, when in the year 2000 Douglas County reported 87.8% of case reports within 12 days of receipt of report. This progress is attributable to the additional communicable disease nurse hired with preparedness funding, use of the Multnomah County Communicable Disease database and Electronic Lab Reporting. The additional communicable disease nurse has also allowed for program growth in community education, Hepatitis C investigations, viral Hepatitis immunization outreach, employee immunizations, and quality assurance reviews.

In year 2007, the Communicable Disease Program served 160 unduplicated clients in direct clinic services in Roseburg and satellite communicable disease clinics.

Further services included 576 epidemiology investigations of reportable diseases and Tuberculosis [TB] case management. This is a large increase in investigations, mostly due to reportable chronic Hepatitis C, compared to the 311 epidemiology investigations completed in 2006.

Douglas County has membership on the CHLO-Epi Committee, and the Multnomah County CD database Committee. In 2007, Douglas County staff assisted DHS with development of two E-learning modules for new staff training on communicable disease reporting and on outbreak investigations.

Chronic Hepatitis C became reportable in July 2005. In 2007, Douglas County had 309 cases of chronic Hepatitis C reported. DCHSS partners with the local community based organization, Harm Reduction Center of Southern Oregon (HRCSO), to screen high risk persons for Hepatitis C. In 2007, DCHSS assisted HRCSO to begin using the Home Access Hepatitis C screening kit to screen for Hepatitis C in high risk individuals, including needle exchange clients. In 2006 and 2007, Douglas County participated in a free Hepatitis C screening project with DHS that targeted high risk persons for Hepatitis C screening and collected epidemiological information about risk behaviors.

b. Goals

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

c. Activities

Target population: Douglas County

a. Provide epidemiologic investigations to report, monitor, and control communicable disease and other health hazards
b. Provide diagnostic and consultative communicable diseases services
c. Assure early detection, education, and prevention activities to reduce the morbidity and mortality of reportable communicable disease, e.g., E-Sentinel, electronic lab reporting.
d. Assure the availability of immunizations for human and animal target populations; target and vaccinate high-risk human populations specifically through special projects aimed at STD, HIV, and Hepatitis C populations

e. Collect and analyze communicable disease and other health hazard data for program planning and management to assure the health of the public
f. Train all public health nurses in communicable disease control, including N95 fit testing of identified staff
g. Maintain Health Alert Network broadcast fax/email system
h. Continue public health preparedness projects, including planning for smallpox, pandemic influenza, strategic national stockpile, mass immunizations, and other preparedness-related projects
i. Continue ongoing discussions with local health care providers and local and reference laboratories regarding timeliness and accuracy of reporting communicable diseases
j. Continue communicable disease education in community settings, e.g., senior centers, doctor offices, health fairs, and among community partners and emergency responders
k. Continue use of the Multnomah County CD database and train additional staff on the database for surge capacity.
l. Continue community collaboration for prevention and management of Hepatitis C
m. Continue CHLO-Epi membership
n. Continue partnership with Douglas County Engineering Department in providing GIS services as needed

d. Evaluation

a. Number of 12 day intervals between receipt of case reports at the County and receipt of case reports at the State, as described in the monthly communicable disease surveillance report as a marker for timely reporting from the local to state level.
b. Number of Days between receipt of case reports at the County and receipt of case reports at the State, as described in the monthly communicable disease surveillance report as a marker for timely reporting from the local to state level.
c. Meeting the Conference of Local Health Officials Minimum Standards for reportable Communicable Disease Control, Investigation and Prevention
d. DCHSS, Public Health staff will report increased knowledge of communicable diseases
e. Results of internal Continuous Quality Improvement reviews
f. Vaccine preventable diseases will decline
g. Compliance during the Annual Program Review conducted by the Oregon Department of Human Services

III.2 Action Plan: Emergency Preparedness

a. Current condition

The major wind and rain storms in December 2007 bypassed Douglas County. In February 2008, Highways 138 and 230 were closed for several days due to hundreds of trees that fell into the roadway and several feet of new snow. Fortunately, there were no injuries or deaths from this event. Douglas County has and will again be affected by major storms, wildfires, floods, and has the potential to be devastated by major earthquakes, tsunamis or pandemic flu. These disasters provide real awareness for the need of all hazards planning and preparedness in the nation and the world. DCHSS must be prepared to identify and respond to bioterrorism as well as natural disasters, outbreaks of infectious diseases, and other threats to protect the health of our community. Improvements in public health preparedness have increased the functional capacity of day-to-day operations for DCHSS. DCHSS staff continue to work and exercise with local and state partners to refine procedures for responding to a broad range of disasters and emergencies.

Some of the major preparedness projects from 2007 include the following:

- DCHSS staff adopted plans for chemical and radioactivity response
- DCHSS signed a Memorandum of Understanding with eleven other Oregon counties
- DCHSS Hazardous Vulnerability Analysis (HVA) has been incorporated into the Douglas County HVA and it has been approved by the Douglas County Board of Commissioners
- In August 2007, DCHSS partnered with the local Red Cross and C.E.R.T. at a preparedness booth at the Douglas County Fair
- Preparedness staff participated in TOPOFF 4
- DCHSS staff has participated in three table tops and one functional exercise
- DCHSS staff participated in “Amber Alert” call center training.

DCHSS included ICS training requirements as part of all staff job descriptions during 2006. As of March 21, 2008 there are currently 134 DCHSS staff trained in ICS 100, 20 in ICS 200, 8 in ICS 300, 6 in ICS 400, 156 in ICS 700 and 10 in ICS 800.

The present workload includes updating and/or developing the following response plans: vulnerable populations, pandemic community awareness, community partner meetings, natural disaster, and Health and Medical Annex. DCHSS also will participate in two table top, functional or full-scale exercises during the next fiscal year.

b. Goals

a. To enhance epidemiological surge capacity to respond to biological threats and disease outbreaks

b. To ensure dissemination of accurate and timely information to the public, doctors, emergency responders, hospitals and other community partners through the Health Alert Network
c. To integrate all hazards preparedness plans and procedures into the Douglas County Emergency Operations Plan
d. To provide improved public health preparedness by establishing mutual aid agreements with community partners and neighboring regional Coos, Curry, and Lane counties
e. To educate DCHSS employees, first responders, and the local health care community about Incident Command System, communicable disease reporting and investigation, public health preparedness issues, and the role of the local health department in an emergency
f. To maintain an emergency medical cache for use by the emergency medical response community (currently located off-site)
g. To participate in local, regional and state wide preparedness exercises
h. To enhance the department's interoperable communications capacity
i. To meet the CD and preparedness reporting requirements as directed in PE 12

c. Activities

Target population: Douglas County

a. Continue development and refinement of emergency response plans, e.g., Strategic National Stockpile distribution, Mass Prophylaxis Plan, Chemical, Radiation, Health and Medical Annex, and All Hazards Plan
b. Maintain the emergency medical cache
c. Continue to offer department staff communicable disease training to augment surge capacity abilities, NIMS, risk communication skills
d. Continue participation in the CLHO-Epi Committee, Region 3 Healthcare Resources Services Administration Board, CHLO Public Health Preparedness Leadership Team, Emergency Management Advisory Group, and Public Information Officer Network
e. Test and train on the county Health Alert Network system and Alert Oregon. Continue 24/7 staff response to public health emergencies
f. Use ICS when dealing with large scale events
g. Continue to plan and/or participate in public health preparedness training and exercises and the local, regional and state levels
h. Continue public education campaigns about emerging diseases, e.g., West Nile Virus, Pandemic Influenza as needed
i. Continue to meet with the Cow Creek Tribe for the development of a tribe emergency plan and a Mutual Aid Agreement
j. Begin to incorporate special population organizations into emergency preparedness plans
k. Continue to acquire and utilize the appropriate computer equipment, radios and wireless technology that meet the interoperable

communications requirements of the County, State and Federal governments

d. Evaluation

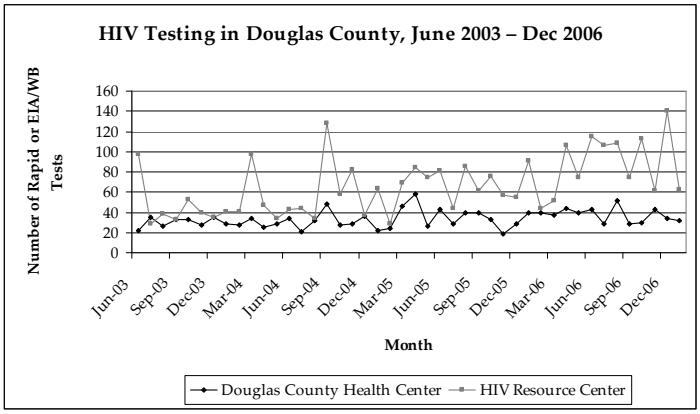
a. Completion of draft chemical, radiological, and natural hazards response plans. Update existing plans as needed and identified during exercises.
b. Revise and update the Douglas County Health and Medical Annex E
c. Documentation of DCHSS responder participation in state and local emergency management planning and training activities
d. Documentation of health department staff participation in NIMS, public health and bioterrorism education
e. Documentation of the transmission of CDC HAN alerts and advisories to healthcare providers, hospitals and emergency responders
f. Compliance during the Annual Program Review conducted by the Oregon Department of Human Services

III.3 Action Plan: HIV

a. Current condition

Douglas County contracts with the Harm Reduction Center of Southern Oregon (HRCSO) to provide HIV Counseling and Testing (CTRS), Outreach to CTRS, Harm Reduction services, and Ryan White CARE Act services. The HRCSO provides HIV counseling and testing to Douglas County and has expanded in recent years to provide HIV prevention services in Coos, Curry, and Josephine counties.

In 2007, DCHSS administered 403 HIV tests and HRCSO administered 875 HIV tests. Of these tests done by DCHSS and HRC in 2007, 51% of the HIV tests were to the high risk populations of Men who have Sex with Men (MSM), IV Drug Users (IDU), MSM/IDU, sex or needle partner is HIV positive, partner at risk, and sex for money/drugs. Specifically, 66 HIV tests were to MSM and MSM/IDU, Oregon's historically highest risk group.



Douglas County and HRCSO implemented rapid HIV testing in May 2005. In 2007, 60% of the HIV tests administered by Public Health were done with the OraQuick rapid test and 99% of the tests administered by HRCSO were done with the OraQuick rapid test. Rapid testing in an expansive rural community saves program resources in return travel to a community to provide test results. Instead, rapid testing provides the results in 20-40 minutes. Douglas County staff has membership on the state CTRS rapid testing workgroup which set planning guidance for use of conventional versus rapid HIV testing for the 2008-2009 fiscal year.

Due to an increased need to address Hepatitis C infection, DCHSS partners with HRCSO to work to integrate Hepatitis C into existing prevention programs e.g. HIV, jail health, primary medical care, alcohol and drug treatment, parole and probation. A key part of the Hepatitis C prevention effort will be the continuation of Harm Reduction Services and Needle Exchange in Douglas County. HRCSO distributed 35,721 syringes in 2007 and disposed of 31,190 syringes. In addition in 2007, DCHSS established a 24/7 drop box located on health department property for safe disposal of community sharps.

HRCSO distributed 11,500 condoms as part of the HIV prevention services. DCHSS distributed 29,448 condoms as part of a joint HIV prevention and family planning service.

HRCSO coordinates the Ryan White Title II Case Management services for HIV positive persons in Douglas County. The health department provides the nursing case management piece 4 hours a week. In 2007, there were an estimated 61 known HIV positive persons living in Douglas County. The Ryan White Case Management program served 38 HIV positive persons during 2007.

The HRCSO has membership on the Oregon State Viral Hepatitis Planning Group. Douglas County has membership on the CHLO-HIV Committee. Public Health Division staff provides ongoing technical assistance to the HRCSO and serve on the HRC Program Evaluation Committee.

In 2007, Douglas County transitioned from new HIV infections being investigated at the state level, to be investigated at the local level.

b. Goals

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

c. Activities

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

a. HIV Counseling and Testing to high risk populations
b. Conduct HIV disease investigation with newly reported positive HIV cases
c. Integrate STD, HIV, and Hepatitis C prevention efforts
d. Target and vaccinate high-risk populations against vaccine–preventable diseases through special projects aimed at STD, HIV, and Hepatitis C populations
e. Increase communicable disease education in community settings, e.g., senior centers, medical providers, health fairs, community agencies, and emergency responders
f. Case management of HIV and AIDS cases at the Harm Reduction Center to meet client needs of case management, medical and dental care, housing, mental health and substance abuse treatment, and transportation
g. Link HCV prevention and management with the current HIV and IDU models in the community

h. Support HRC ongoing efforts, e.g., coordinate publicity for National HIV testing day, complete quality assurance for RWCA case management program, coordinate joint HCV efforts

d. Evaluation

a. Number of HIV tests done at DCHSS and HRC to high risk populations
b. Return rate for HIV results at DCHSS and HRC
c. Number of condoms distributed at DCHSS and HRC
d. Number of syringes exchanged at HRC
e. Number of Hepatitis B and C testing done at DCHSS to high risk populations
f. HIV and AIDS rates in Douglas County
g. Number of Hepatitis A and B immunizations to high risk populations
h. Number of PLWHA receiving case management services
i. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

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

a. Current condition

Douglas County provides a Sexually Transmitted Disease clinic three days a week. Douglas County also provides Sexually Transmitted Disease Case Management Services that includes case finding and disease surveillance, medical supplies, health care provider services, clinical and laboratory diagnostic services, treatment, prevention, and education activities.

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

Douglas County receives no state funding dollars to operate a STD Program. Douglas County does receive from the state 'In-Kind Resources' of antibiotics for treating STDs and receives Technical Assistance Resources of a Disease Intervention Specialist that is assigned to our region.

Chlamydia is the most frequently reported STD. Douglas County reported 194 cases in 2007. In 2007, DCHSS diagnosed 80 cases (41% of the reported Chlamydia cases) in Douglas County through the STD Clinic and Family Planning Clinic services. In 2007, DCHSS served 954 unduplicated clients in the STD Program with a total of 1,222 STD clinic visits. In 2007, DCHSS provided 474 tests for Gonorrhea, 1,454 tests for Chlamydia, and 208 tests for Syphilis.

b. Goals

a. Prevent or minimize neonatal morbidity due to reportable bacterial STIs and conditions, including pelvic inflammatory disease (PID) and lymphogranuloma venereum.
b. Preserve fertility.

c. Diminish or prevent catastrophic consequences, such as stillbirths, congenital syphilis, miscarriages, chronic infection, and chronic pelvic pain due to STDs.
d. Reduce the prevalence of STDs.
e. Address STIs, including reportable, acute and chronic viral infections such as hepatitis A, B, and C, and HIV; and non-reportable chronic viral infections such as HPV, and HSV, as resources permit.
f. Use effective, population-based, public health practices which are likely to reduce the reproductive number of an STD. Reducing the reproductive number of an STD requires that at least one of the following occurs: 1) Shorten the average duration of infection. Methods include: early diagnosis and treatment, case investigation, follow-up and partner services, 2) Reduce the average probability of transmission per partner sexual contact. Methods include: condom use, fewer sex acts, and/or 3) Decrease the average number of sexual partners per unit of time. Methods include changing individual and community norms; encourage monogamy and serial monogamy; decrease number of concurrent partners.

c. Activities

a. Ensure a system for STD surveillance.
b. Ensure the evaluation and treatment of individuals with reportable, bacterial STDs, including PID (STD eval/treatment).
c. Ensure that others at risk for infection (sex partners, associates, suspects, and clusters) are identified and offered evaluation and treatment (partner services).

d. Evaluation

a. Chlamydia rates in Douglas County
b. Gonorrhea rates in Douglas County
c. Early syphilis rates in Douglas County

III.5 Action Plan: Tuberculosis

a. Current condition

Tuberculosis rates for the population of Douglas County remain stable at an incidence rate of 1% - 2% for the population from 2002-2007. This is below the state average of 2.2% - 3.2% for the same time period. In 2007, there was one diagnosed active TB case in Douglas County. There have been several suspect cases annually that take substantial staff time to case manage until the time that active TB has been ruled out.

In 2003, Douglas County implemented the use of Direct Observed Therapy with Tuberculosis patients. Although a standard of care, the use of this daily observation of a TB case swallowing their medication has placed a financial burden on local health department resources. Nursing staff complete annual fit testing for N95 masks as required.

In 2007, Douglas County administered 390 PPD tests. Also in 2007, there were 4 clients that were monitored for latent TB infection.

b. Goals

a. To have early and accurate detection, diagnosis, and reporting of TB cases leading to initiation and completion of treatment
b. To provide comprehensive case management to active TB cases, including Directly Observed Therapy
c. To identify contacts of patients with infectious TB and treat those at risk with an effective drug regimen.
d. Maintain or meet the National TB Priority Indicators and Program Objectives
    a. Increase the percent of patients with newly diagnosed TB, for whom therapy for 12 months or less is indicated, will complete a course of curative TB treatment within 12 months of initiation of treatment to 93% by 2015
    b. Decrease the TB rate in US born to no more than 0.7 cases/100,000 by 2015 ** Increase the average yearly decline in TB rates in US born to at least 11%
    c. Decrease the TB rate in foreign born to no more than 14 cases/100,000 by 2015**Increase the average yearly decline in TB rates in foreign born to at least 4%
    d. Decrease the TB rate in US born non-Hispanic blacks to no more than 1.3 cases/100,000 by 2015
    e. Decrease the TB rate in children less than 5 years of age to no more than 0.4 cases/100,000 by 2015
    f. Increase the percent of sputum-AFB-smear-positive TB patients with at least one contact listed to 100% by 2015

g. Increase the percent of contacts to sputum-AFB-smear-positive TB cases who are evaluated for infection and disease to 93% by 2015
h. Increase the percent of contacts with newly diagnosed latent TB infection who have started treatment to 88% by 2015
i. Increase the percent of contacts with newly diagnosed latent TB infection who started treatment and have completed treatment to 79% by 2015
j. Increase the percent of culture-positive TB patients with initial drug susceptibility results reported to 100% by 2015

e. To educate the health care providers and general public regarding tuberculosis
f. As needed, to identify settings in which a high risk exists for transmission of Mycobacterium tuberculosis and apply effective infection-control measures

c. Activities

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

a. Asses the extent and characteristics of TB in the jurisdiction through collection and analysis of epidemiologic and other data
b. Develop policies and procedures and a plan for controlling TB
c. Assure diagnostic, clinical, and preventive services needed to implement the plan for controlling TB
d. Provide information and education to policy makers, health-care professionals, and the public regarding control of TB in the jurisdiction
e. Train public health staff in communicable disease control, including N95 fit testing of identified staff
f. Continue communicable disease education in community settings, i.e., jails, homeless shelters, medical offices, health fairs, and community partners
g. Continue bi-weekly Communicable Disease clinics that offer Tuberculosis medication refills, and monitoring for side effects for eligible clients
h. Complete community assessment of targeted testing and treatment of latent tuberculosis infection, as resources permit.

d. Evaluation

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

III.6 Action Plan: West Nile Virus

a. Current condition

West Nile Virus [WNV] appeared in Oregon in 2004 with the first human, avian, and equine WNV cases diagnosed in August 2004. Since that time (including 2007), no animals or birds have tested positive in Douglas County. However, there was one human death attributed to WNV in 2006 in Douglas County but it has been determined that the victim was probably exposed out of state sometime in 2005.

Because Douglas County does not have a vector control program, sentinel chicken surveillance, nor mosquito surveillance in place at this time, enhanced prevention education is an important strategy to address the potential risk of WNV. This strategy can promote public cooperation and involvement in reducing man-made collections of stagnant water in which mosquitoes breed; help individuals reduce their risk of being bitten by mosquitoes; and educate health care providers about the virus, its prevention, diagnosis and treatment of human encephalitis, and reporting requirements.

Currently there is no local supply of mosquito fish (gambusia) large enough to support the probable demand from Douglas County residents.

Environmental Health attended a national West Nile Virus conference in February 2005. The Environmental Health Division presented information about West Nile Virus to the Douglas County commissioners also in February 2005. The state veterinarian trained local hospital physicians in April 2005 and gave a separate training to the general public a week later. Media messages were disseminated via brochures, press releases and the county website in 2007 and media messages will continue to be disseminated in 2008.

b. Goals

a. Improve public knowledge of WNV and WNV prevention methods
b. Ensure that DCHSS staff are properly trained to 1) respond to questions from the public on mosquito related issues and, 2) conduct surge capacity surveillance activities

c. Activities

Target population: Douglas County, especially citizens at highest risk for disease

a. Conduct WNV surveillance activities
b. Develop and disseminate a public education campaign that may include, but is not limited to: TV and radio spots, fact sheets, posters, paycheck or billing inserts, news releases, website information, mailings to community

groups, community presentations, school education, reporting and treatment information to health care providers, and a DCHSS telephone hotline.

c. A telephone hotline may be utilized in the event that local capacity exceeds telephone demands
d. Participation in Oregon's dead bird surveillance network.
e. Consider implementation of a vector control program; educate the public and government officials about vector control programs

d. Evaluation

a. Number of dead birds (Corvid family) collected and tested for presence of WNV
b. Number of reported human cases of WNV
c. Number of local media spots on radio, television, and newspaper about WNV
d. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

III.7 Action Plan: Women, Infant, Child (WIC)

See the attached 2008/2009 WIC Nutrition Education Plan, WIC Staff Training Plan, and Evaluation of 07/08 WIC Nutrition Education Plan.

III.8 Action Plan: Family Planning

a. Current Condition

The Douglas County Partnership for Healthy Teens Coalition continues to be strong and active in the community. Its mission is to work together through community partnership to provide services for teens that reduce adolescent pregnancy rates in Douglas County. The Coalition continues to build capacity through collaboration and participation with local and state groups that address all areas of adolescent health, including drug prevention, homelessness, and juvenile justice. The Healthy Teens Coalition also works to build community involvement and support for local effort to help teens develop the skills and strengths to build healthy futures. Each year, the Coalition solicits funding to host a STRIVE Conference (Successful Teens Reaching Inward for Vision and Empowerment), which provides information to teens about healthy relationships, teen pregnancy prevention, sexually transmitted diseases, drug abuse, self-esteem and refusal skill strategies.

The Douglas County STARS Program has been well-received in Douglas County. This successful teen pregnancy prevention program is delivered in twelve of the thirteen Douglas County school districts. The STARS Program, in coordination with our clinical care program, has helped to reduce the number of unplanned pregnancies in Douglas County, and has helped to keep our teen pregnancy rate below 10.0 /1,000 births.

Budget cuts to the Public Health Division in fiscal year 2008-2009 will reduce the STARS coordinator position from 0.9 FTE to 0.4 FTE. Public Health is exploring ways to reduce and reconfigure the delivery of STARS and the Healthy Teens Coalition. An effort will be made to prevent the disruption of teen pregnancy prevention efforts in local school districts and to provide sufficient outreach to avoid a potential increase in Douglas County's teen pregnancy rate.

Family Planning clinic services continue to offer contraceptive and reproductive health counseling, initial and annual reproductive health exams, screening tests and/or treatment for sexually transmitted diseases, and a variety of available birth control methods through the main Roseburg clinic and three outlying clinics. The clinics provide appointment visits as well as drop-in clinics. There are drop-in clinics for contraceptive counseling four days per week in Roseburg, and one to two days per week in the outlying offices. The Roseburg clinic also schedules an evening clinic once a week. These health department services have resulted in averting 621 pregnancies, and serving over 4, 596 (61.8%) women in need (DHS/ALHERS data, 2007).

With cuts in the 2008-2009 Public health budget, there will be one nurse practitioner position cut. In the past, it has been difficult to recruit and hire nurse practitioner staff for the Family Planning Clinic. With fewer than needed nurse practitioners,

clinics continue to operate in a consistent manner but with decreased availability of appointment times for initial and annual exams.

During 2007, the Reproductive Health Care Program has provided screening, education, counseling and referral for vasectomy services. The medical provider that was providing these services on contract with the health department has recently retired. A new medical provider has not yet been identified.

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

b. Goals

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

c. Activities

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

a. Ensure adequate follow-up for abnormal pap smears through pap tracking system.
b. Ensure adequate screening for Chlamydia following the Region X infertility Prevention Project screening guidelines.
c. Evaluate monthly no-show rates by site.
d. Continue to conduct semi-annual client satisfaction surveys.
e. Continue to provide appropriate and available methods for birth control.
f. Maintain continuing education opportunities for professional and support staff activities.
g. Maintain the number of middle and high school presentations about available services to teens, pregnancy prevention, and STD/HIV education.
h. Review the current STARS Program and implement a reconfigured program
i. Continue reproductive health exam, contraceptive counseling visits, and education in Roseburg and all outlying offices.

d. Evaluation

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

III.9 Action Plan: Perinatal Health

a. Current condition

Due to budget cuts, DCHSS will eliminate the Prenatal Clinic Program in July 2008. The Prenatal Clinic has provided prenatal care for 200-300 pregnant females a year in a community where the number of physicians providing prenatal care in Douglas County has decreased over the last several years; the Reedsport area of the county has no prenatal care provider.

Douglas County currently has Public Health Nurses that provide Maternity Case Management (MCM) home visits to their assigned geographic area. The complexity of services needed has increased tremendously with the difficult issues of alcohol, drugs, mental health and violence. These continue to be ongoing challenges as we strive for healthy pregnancies. The MCM Program has implemented mandatory education surrounding fetal alcohol, HIV and pregnancy, tobacco use, dental health, lead and pregnancy, immunizations, and early childhood caries prevention into their comprehensive program.

Budget cuts to the Public Health Division in fiscal year 2008-2009, will result in the loss of one Maternity Case Management Program field nurse position. The reduction of a field nurse position not only means a struggle to meet Maternity Case Management program goals, but also means reduced capacity to meet clinic demands, e.g., Immunizations, STD, HIV, Family Planning, or Communicable Disease.

The Public Health Division is working in to reduce the rate of tobacco use among pregnant women by including tobacco use screening and counseling as part of all clinic and home visit encounters. Home visit nurses are trained to use the 5As -- a scientifically proven five-step smoking cessation counseling method to increase smoking cessation among the women they serve. The March of Dimes-Greater Oregon Chapter has awarded a $10,000 grant to Douglas County Public Health to address maternal smoking in Douglas County. The purpose of the grant is to help fulfill the mission of the March of Dimes to prevent birth defects, premature birth and infant mortality. The grant will allow Douglas County Public Health to implement “Tobacco Free Baby & Me — a program that has been successful in helping women to quit smoking during pregnancy and to stay quit after the birth of their baby. In addition, the Health Care Coalition of Southern Oregon has awarded Douglas County a $7,275 grant which will implement health care provider mobilization to integrate 5As into each clinic encounter with pregnant women and women of childbearing age through out the county.

Douglas County has continued to participate in the Oregon Mothers Care Program. With the Public Health Division as an Oregon Mothers Care site, we hope to increase the number of women receiving first trimester prenatal care by being a

liaison for them with OHP and other needed services during their pregnancy (WIC, prenatal care provider, home visiting services, etc.).

b. Goals

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

c. Activities

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

a. Pre-conceptual counseling
b. Pregnancy and Parenting Education
c. Referral to Community Resources, e.g., WIC, Maternity Case Management, Family Planning

d. Evaluation

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

III.10 Action Plan: Child Health

a. Current condition

DCHSS has Public Health Nurses that provide Babies First! and Targeted Case Management home visits to their assigned geographic area. Two of these positions are funded through a federal grant for "Eliminating Disparities" and reducing infant mortality in targeted zip codes and the Hispanic population. Alcohol, drugs, mental health and violence increase the complexity of needed services. These continue to be ongoing challenges as we strive for a healthy baby. The Public Health Division participates in the Douglas County Multi-Disciplinary Child Abuse Team and the Douglas County Child Fatality Review Team. These teams work to decrease child abuse and mortality.

The Babies First! Program has expanded to include dental and hearing screening. The program provides dental health screening and referral to a dentist at one year of age. The early hearing detection portion consists of screening by one month of age, diagnosis of hearing loss by 3 months of age, and referral to Early Intervention services by 6 months of age.

Budget cuts to the Public Health Division in fiscal year 2008-2009, will eliminate one field nurse position from the Babies First! Program. The reduction of a field nurse position not only means a struggle to meet Babies First! program goals, but also reduces our capacity to meet clinic staffing demands, e.g., Immunizations, STD, HIV, Family Planning, or Communicable Disease.

DCHSS provides a Public Health Nurse under contract with the local ESD to provide nurse delegation for special needs children within the school environment. This same nurse provides home case management services for children with special health care needs through the state CaCoon program.

DCHSS provides home visiting services through the Healthy Start Program that has recently received statewide accreditation through the Prevent Child Abuse America/Healthy Families America national center. These home visits are provided on a voluntary and weekly basis by Family Support Workers to first time families, either prenatally or at the birth of their first child and can continue through three years of age. The presence of various factors associated with the increased risk of child maltreatment or other poor childhood outcomes, such as social isolation, substance abuse or parental history of abuse in childhood is assessed. The focus of these visits is to promote effective parent-child relationships and healthy growth and development by providing information and education on positive, supportive, nurturing parenting skills, bonding and attachment and information on child and brain development.

Budget cuts to the Public Health Division in fiscal year 2008-2009 will eliminate one Family Support Worker from the Healthy Start Program. To sustain the Healthy

Start Program, the Public Health Division will need to secure $49,000 in outside support. The local Commission on Children & Families and the Healthy Start Advisory Board are exploring the possibility of sitting Healthy Start outside of the local health department for fiscal year 2008-2009 to help reduce employee benefit costs charged to the Healthy Start Program.

The Healthy Start Family Support Workers and Public Health Nurses often work collaboratively to meet the complex health and social service needs of children and families. The Public Health Division Director and the Division's Healthy Start Program are represented on the Douglas County Early Childhood Planning Coalition.

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

b. Goals

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

c. Activities

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

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

a. Education, screening and follow up, counseling, referral, or health services for family planning, perinatal care, infants, and children
b. Screening and physical exams that evaluate developmental achievements, growth parameters, immunization status, hearing & vision acuities, speech and language development, and provide ongoing education, information and referral
c. Provide and coordinate varied programs to meet parent and child needs in Douglas County; WIC Program, Immunization Clinic services, Family Planning services, Maternity Case Management, Targeted Case Management through the Babies First Program, CaCoon Coordination, and Healthy Start Programs.
d. Continue membership in the Douglas County Multi-Disciplinary Child Abuse Team, Douglas County Early Childhood Planning Coalition, and Douglas County Child Fatality Review Team

d. Evaluation

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

III.11 Action Plan: Adolescent Health

a. Current condition

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

Budget cuts to the Public Health Division in fiscal year 2008-2009 will reduce the STARS coordinator position from 0.9 FTE to 0.4 FTE. Public Health is exploring ways to reduce and reconfigure the delivery of STARS and the Healthy Teens Coalition. An effort will be made to prevent the disruption of teen pregnancy prevention efforts in local schools and to provide sufficient outreach to avoid a potential increase in Douglas County's teen pregnancy rate.

DCHSS subcontracts with the local FQHC to provide a School Based Health Center at Roseburg High School. DCHSS and the FQHC submitted a SBHC expansion grant in 2007-2008 for Douglas High School in the Winston-Dillard School District. This grant is in process, with the community looking to a 2009 implementation.

b. Goals

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

c. Activities

a. To continue outreach activities that target child and adolescent health

d. Evaluation

a. The percentage of students in school, grades 9 through 12, who report never having had sexual intercourse
b. The percentage of students in school, age 15 through 17, who report having first sexual intercourse before the age of 15
c. The percentage of previously pregnant 9th through 12th grade females who report more than one pregnancy
d. The percentage of contraceptive use at last intercourse by students in grades 9 through 12 who are currently sexually active
e. Douglas County's teen pregnancy rate: number of pregnancies per 1,000 females age 15 through 17
f. Oregon's teen pregnancy rate: number of pregnancies per 1,000 females age 10 through 17
g. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

III.12 Action Plan: Immunizations

See the attached 2008/2009 Immunization Annual Plan.

III.13 Action Plan: Oral Health

a. Current condition

In September 2005, Douglas County was re-designated by the Health Resources & Services Administration (HRSA), Bureau of Health Professions as a dental health care shortage area. The ratio of population to dentist is 10,457:1 and contiguous county resources are inaccessible or excessively distant. Inadequate dental coverage and limited access to oral health care pose a significant risk for low income children, families, and older adults. There are no fluoridated water systems in Douglas County, and contiguous county resources are designated as HPSA and/or are geographically inaccessible due to long distances and the unavailability of public transportation.

Budget cuts to the Public Health Division in fiscal year 2008-2009 will reduce our capacity to provide oral health screening, education, or urgent care for uninsured or under insured children or adults. The following oral health promotion services will not be provided by our Health Education Program in fiscal year 2008-2009: population-based oral health education; grant writing for school or community-based oral health screening, education, or direct care; coordination and collaboration volunteer dentists, dental assistants, hygienists, the Umpqua Dental Society, Umpqua Community College Dental Assistant Program, Medical Teams International, or local schools, agencies, or churches.

b. Goals

a. To provide access to preventive oral health for uninsured & underinsured children, adolescents, and adults (Healthy People 2010, 21-1)

c. Activities

a. Provide oral health education in coordination with routine Public Health Division Programs, e.g., Home Visit Program, WIC.

Target population:

a. Uninsured and underinsured children, adolescents, and adults in Douglas County
b. Uninsured and underinsured pregnant women who receive services through Douglas County Public Health Programs

d. Evaluation

a. Number of uninsured and underinsured children, adolescents, and adults who receive Public Health Division programs.

III.14 Action Plan: Nutrition and Physical Activity

a. Current condition

Poor nutrition, physical inactivity, and obesity are risk factors that increase the risk of early onset diabetes and other preventable chronic diseases. Among youth, only 22.1% of 8th and 17.5% of 11th graders in Douglas County report eating the recommended 5 fruits and vegetables per day (Oregon Healthy Teen, 2006). Only 36.4% of 8th graders and 29.2% of 11th graders report being physically active for at least 60 minutes per day, seven days per week. Not surprisingly, 28.9% of 8th graders and 25.5% of 11th graders in Douglas County are overweight or at risk for overweight.

The Public Health Education Program pursues opportunities and collaborations to promote nutrition and physical activity. For the past few years, the Health Education Program has convened the Healthy Active Douglas County Team to attend the annual Healthy Active Oregon Training Institute on nutrition and physical activity. Team members represent public health, healthcare, schools, city planning, private business, parks and recreation, and health & fitness.

The Healthy Active Douglas County Team identified three priorities: (1) to promote active community environments, and (2) to promote worksite wellness, and (3) to increase community awareness of nutrition and physical activity issues. Physical activity and promotion efforts over the past year have resulted in increased media coverage of physical activity and worksite wellness.

Budget cuts to the Public Health Division in fiscal year 2008-2009 will curtail Public Health Education Program staff involvement in all nutrition and physical activity efforts. Participation in nutrition and physical activity will be addressed primarily through the Douglas County WIC Program and in coordination with health education to individuals/families who receive services through the various Public Health Division programs (e.g., Nurse Home Visit, Family Planning).

b. Goals

See the attached 2008/2009 WIC Nutrition Education Plan, WIC Staff Training Plan, and Evaluation of 07/08 WIC Nutrition Education Plan.

c. Activities

See the attached 2008/2009 WIC Nutrition Education Plan, WIC Staff Training Plan, and Evaluation of 07/08 WIC Nutrition Education Plan.

Target population: Douglas County

d. Evaluation

See the attached 2008/2009 WIC Nutrition Education Plan, WIC Staff Training Plan, and Evaluation of 07/08 WIC Nutrition Education Plan.

III.15 Action Plan: Substance Abuse

a. Current condition

Douglas County adults smoke at a higher rate (27%) than adults statewide (20%) (DHS Tobacco Facts, 2007). Among youth, 15.1% of 8th grade students and 21.7% of 11th grade students report current smoking. Nearly one in four women (23.9%) in Douglas County report using tobacco during pregnancy, as compared to 12.3% statewide (DHS Tobacco Facts, 2007). Tobacco costs Douglas County residents nearly $98.9 million per year in direct medical costs and indirect costs due to lost productivity due to tobacco-related deaths (DHS Tobacco Facts, 2007).

Douglas County Public Health Division programs include tobacco prevention education in coordination with all of its client and community-based programs and services. The Prenatal Clinic Care, Family Planning, Maternity Case Management, Babies First, Healthy Start, and WIC Programs all serve as important touch points for targeted client education about the risks of tobacco use during the preconception, pregnancy, and postpartum periods. Risk screening and counseling are important elements of all clinics and home visit encounters.

Douglas County Public Health is a recipient of Tobacco Prevention and Education Program (TPEP) funding for January 2008 through June 2009 funding cycle. The Public Health Education Program provides coordination of the grant project, including grant writing and reporting, program planning, implementation, and evaluation. Public Health Education staff represent Public Health on local drug prevention task groups and coalitions, and convenes groups for carrying out TPEP grant activities.

See also Action Plan for Perinatal Health.

b. Goals

a. Reduce exposure to secondhand smoke
b. Reduce tobacco use during pregnancy
c. Countering pro-tobacco influences
d. Reduce youth access to tobacco
e. Promote quitting among youth and adults
f. Enforce Oregon's Indoor Clean Air Act
g. Reduce the burden of tobacco related disease

c. Activities

a. Work with community partners to raise awareness of the problem of tobacco use in Douglas County
b. Conduct targeted best-practices for tobacco prevention

c. Provide tobacco prevention education in coordination with Public Health Division Programs
d. Provide evidence-based smoking cessation counseling in coordination with Maternity Case Management, Nurse Home Visit Program
e. Represent DCHSS on local drug prevention committees and coalitions
f. Implement

Target population: Douglas County

d. Evaluation

a. Monitor local data on alcohol, tobacco, and other drug abuse in Douglas County, e.g., Oregon Healthy Teen Survey, Behavioral Risk Factor Surveillance System, Oregon Benchmark reports
b. Evaluation as required in coordination with TPEP grant program funding

III.16 Action Plan: Child Injury Prevention

a. Current condition

Unintentional injury is the number one killer of children in the U.S., taking more lives than disease, violence, and suicide. According to data compiled by the Oregon Child Injury Prevention Program, 15.4% of Douglas County children age 0-14 died as a result of unintentional injury, as compared to 8.5% statewide from 1999 to 2003. From 1998 -2002, 239 Douglas County children were hospitalized for unintentional injuries (approximately 48 children per year). The leading causes of unintentional injury to Douglas County children 0-14 years of age are: motor vehicle occupancy, bike/helmet, falls, and poisoning.

The Public Health Education Program has worked to reduce child injury in three key areas: (1) child passenger safety, (2) bike helmet education, and (3) home safety. Douglas County Public Health Division is host to the only permanent safety seat fitting station in Douglas County, responds to public inquires, conducts safety seat promotions, conducts monthly safety seat education classes, and has held at least one community safety seat installation clinic per year. Public Health Education is the local Safe Kids site, and two staff are certified as child passenger safety seat technicians.

The Public Health Education Program has continued to pursue partnerships and funding to purchase bike helmets and bike safety education materials. Small grants from Safe Kids, Emergency Medical Services for Children, and Douglas County Traffic Safety Commission have helped to purchase helmets, bike safety education videos, and child/parent education booklets that have been distributed to law enforcement agencies throughout Douglas County.

The promotion of fall and home safety (e.g., crib safety, fall prevention, poisoning prevention, burn prevention) is conducted in coordination with the Public Health Division Nurse Home Visiting and Healthy Start Programs.

Budget cuts to the Public Health Division in fiscal year 2008-2009 will significantly reduce the capacity of the Public Health Education program to promote child injury prevention. Public Health Education capacity to conduct child passenger safety seat education will be significantly reduced, and Public Health Education staff involvement in bike safety, helmet use, and all other population-based child injury prevention efforts will be eliminated completely. Client-based Public Health Division programs will continue to provide child injury prevention in coordination with direct services to individuals/families.

b. Goals

a. To promote proper use of child passenger safety seats.

b. To provide child passenger safety seats to low-income families
c. Decrease the number of children ages 0-14 who are injured in the home from poisonings, falls, fire and burns.

c. Activities

a. Maintain at least one Public Health Education staff child passenger safety seat technician certification
b. Child Passenger Safety Seat education and seat distribution
c. Pursue partnerships and funding to support child passenger safety seat education in Douglas County
d. Promote child injury prevention through Public Health Division programs, e.g., Nurse Home Visit, Healthy Start.

Target population: Douglas County

d. Evaluation

a. Number of child safety seat education contacts
b. Number of child safety seats distributed to low-income families annually..
c. Number of children injured motor vehicle crashes.*
d. Number of children with poisoning related injures annually.*
e. Number of children with fire/burn related injuries annually.*
f. Number of children with in-home falls-related injuries annually.*

* Data compiled and provided by Oregon Child Injury Prevention Program.

III.17 Action Plan: Health Statistics

a. Current condition

Birth and death reporting, recording, and registration are provided by the Roseburg DCHSS office. Due to the geographic size of Douglas County, the outlying offices in Canyonville and Drain provide completed and registered birth certificates to customers. In 2006, DCHSS implemented electronic death registration but full implementation has yet to occur. Only one county physician participates in electronic death registration. DCHSS implemented electronic birth certificates in January 2008.

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

The Deputy Medical Examiner, with the Douglas County Sheriff's Office, notifies DCHSS of all child deaths, unusual deaths that may have public health significance, and deaths related to communicable diseases. Child deaths are reviewed by the Douglas County Child Fatality Review Team. Cases of attempted suicide are also reviewed by this team. The Medical Examiner serves multiple Southern Oregon counties and works out of Three Rivers Hospital, Grants Pass.

b. Goals

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

c. Activities

Target population: Douglas County

a. Data collection and analysis of health indicators related to morbidity and mortality
b. Birth and death reporting, recording, and registration
c. Analysis of services provided with technical assistance from the Department of Human Services
d. Requests from walk-in customers are filled while the customer waits, once the customer's identification has been proven, their right to obtain a copy of the record has been established, and payment made. Certified copies of registered birth and death certificates are issued within one (1) working day of request.
e. Death certificates are usually ordered by the funeral home. These orders are filled the day of request
f. Birth and death certificates are ordered by customers. Once the foregoing criteria are established, the certificate is mailed

d. Evaluation

a. Percent of birth and death certificates provided within 24 hours of receipt
b. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

III.18 Action Plan: Information and Referral

a. Current condition

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

DCHSS telephone numbers and facility addresses are listed in phone directories, local newspapers, brochures, local and state websites, and community resource directories. The DCHSS reception areas and outlying clinics in Reedsport, Drain, and Canyonville are open from 8 AM - 5 PM, Monday through Friday.

DCHSS has two Public Health Nurses that are out-stationed at the Self-Sufficiency & Employment Program, Department of Human Services, SDA District 6 office. These nurses provide information and referral services to the AFS clients, specifically around health needs.

DCHSS provides information and referrals that are culturally appropriate. DCHSS utilizes a Portland-based interpreter telephone service as necessary for language translation.

The Public Health Division publishes a quarterly Health Matters report on the pertinent public health issues in Douglas County. The Health Matters report is distributed quarterly to over 600 recipients representing all sectors and regions of the county.

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

b. Goals

a. To post and/or update information on the DCHSS webpage
b. To integrate functions within DCHSS to streamline services from all divisions, providing better service to customers
c. To keep all information available to the public as current as possible

c. Activities

Target population: Douglas County

a. Review and revision of phone book listings to ensure accuracy and ease of use

b. All brochures and other resources are reviewed annually and updated as needed

d. Evaluation

a. Public Health customer satisfaction survey
b. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

III. Action Plan: Environmental Health

a. Current condition

Environmental factors have a great impact on the health of the community and quality of life. DCHSS works to establish and maintain a broad based approach to environmental health service delivery. Efforts are focused upon the influence and impact of environmental factors, both natural and manmade, and the management and control of these factors so as to prevent and control illnesses, in order to promote health. Local environmental health services are required by ORS 431.416 with specific standards performed or programs availability assured as authorized by OAR Chapter 333-014-00050. Services in Environmental Health include state-mandated health inspections, licensing & plan review of restaurants, public pools & tourist facilities, certification of food handlers, food borne illness disease investigations, oversight of public drinking water systems, West Nile Virus surveillance and education, environmental health education, disaster response, and animal bite investigations. In fiscal year 2006-2007, 1,051 inspections were conducted at the various licensed facilities and institutions, with 3,200 violations noted. The general public reported 36 complaints, with 10 reporting a food-borne illness, and 0 food-borne illness outbreak investigations were done.

The Environmental Health Division has been moved from a Division to a Program level within the Public Health Division. This changed supervision to the Public Health Division Director. A Program Supervisor was assigned within the Environmental Health Program. In 2007-2008 fees were changed for Temporary Food Service Licenses. This change required operators to register 3 working days prior to an event or pay a late fee. An evaluation of the Environmental Health fee structure is currently being conducted. Program fees are expected to increase significantly in 2008-2009 due to the expected loss of the federal timber safety net dollars. No fee adjustments have been made since 2004.

The Douglas County Public Works Department manages and operates a solid waste disposal and recycling program. At the twelve free-of-charge county transfer sites and one central landfill, the environment is protected and public health hazards reduced or eliminated. Private solid waste franchises provide adequate collection and disposal services. A fee for dumping Demolition Waste was established in January of 2007. In the face of reduced County General Funding, the discussions have arisen again about imposing a fee structure for businesses or for citizens utilizing the dump.

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

The Douglas County Planning Department has taken over responsibility of on-site wastewater management from Oregon's Department of Environmental Quality (DEQ). DEQ is still responsible for other environmental programs within the county

such as spill response, underground fuel storage tanks, air emissions, stream monitoring and waste disposal.

The Department of Agriculture performs all program responsibilities of shellfish sanitation. They determine when a recreational shellfish harvest closure is considered, when “Red Tide,” “Domoic Acid,” or sewage contamination affects shellfish digging areas and when public notification is warranted. Through our food facility inspection program, restaurants that serve shellfish are monitored to assure shellfish products are from licensed and approved sources. The required identification tags are to be collected and maintained by the food facility.

b. Goals

To be vigilant in its continuous and ongoing efforts to reduce or eliminate environmental health risk factors that has the capacity to cause human suffering, disease, or injuries.

c. Activities

Target population: Douglas County

a. Inspection, licensure, consultation and complaint investigation of food services, tourist facilities, institutions, public spas and swimming pools, drinking water systems, to assure conformance with public health standards
b. Environmental Health assessment and planning
c. Food handler training for food service workers in the proper methods of storing, preparing, and serving food
d. Information and referral services to the public and governmental agencies.
e. Investigation of community health hazards, reported animal bites, and diseases that potentially associate or relate to food or water
f. Provides West Nile Virus surveillance and education
g. Lead poisoning prevention

d. Evaluation

a. The number of violations identified in food service establishments
b. The number of complaints received concerning licenses facilities
c. The number of Foodborne Illness (FBI) complaints received
d. The number of FBI outbreaks reported and investigated
e. Maintain inspection frequencies of at least 90% in the number of food service facilities, tourist facilities, school and public facilities food service operations, public spas and pools, shelters and correctional facilities
f. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

III. Action Plan: Safe Water

a. Current condition

Every community is faced with the threat that domestic water supplies may become contaminated and gives rise to communicable disease transmission and/or objectionable taste or odor problems. Should the improper disposal or spill of hazardous materials occur in surface waters, associated drinking water supplies would become at risk. Inadequate drinking water systems and/or substandard waste water treatment are factors which potentate the transmission of water-borne illnesses. Annually 22 public water systems are surveyed on site to assure proper construction and operation. Water lab test results, required to be completed routinely by the water system operator, are monitored for levels of chemical contaminants and any existence of indicator microorganisms.

b. Goals

a. To advise the general public of water-borne contaminants that may produce health risks from bodily contact (e.g. swimming or wading)
b. To follow-up on all disease outbreaks and emergencies including spills that occur in Douglas County
c. To complete all of the grant assurances including surveys, alerts, ERP reviews, and SNC management.

c. Activities

Target population: Douglas County

a. Provide technical and compliance assistance to all operators of public drinking water systems when these systems are found to be in violation of public health requirements and safe water quality standards
b. Investigate every incident of hazardous chemical spill or contamination; maintain membership in Oregon Emergency Response System (OERS)
c. Annual review and update of the Douglas County written plan for responding to emergencies that involve public water systems
d. Provide printed and verbal information regarding the development of safe water supplies to people using onsite water wells and springs as requested.

d. Evaluation

a. Number of required monitoring and reporting violations identified with public water systems.
b. Number of required monitoring and reporting violations identified of public water systems

c. Responses to water systems identified in significant noncompliance (SNC) and Alerts with water quality or monitoring standards
d. All public water systems are provided with consultation and technical guidance when found in violation of safe water quality standards or who fail to monitor
e. At least 22 sanitary surveys completed annually
f. Compliance during the Triennial Program Review conducted by the Oregon Department of Human Services

IV. Additional Requirements

a. See the attached organizational chart of the local health department

b. Senate Bill 555:

The Douglas County Commission on Children and Families (CCF) is under the governance of the Douglas County Board of Commissioners. The local Commission director and the DCHSS Public Health Division Director have established a working relationship to provide services and care to children and families of Douglas County. The Public Health Division Director has been involved from the early planning phases of all parts of the Senate 555 Plan. Together, the Public Health Division Director and the local CCF Director have coordinated trainings for the community on child development, brain research, and have worked closely with the community to have a smooth, coordinated, and united home visit program between Babies First/Maternity Case Management and Healthy Start.

V. Unmet Needs

a. Adequate Funding for Public Health

Douglas County continues to have many unmet public health needs, the largest of which is lack of public health funding. Budget cuts to the Public Health Division in fiscal year 2008-2009 will exacerbate an already diminished capacity to provide basic public health services, much less to respond to threats to public health. Rural timber communities across Oregon and the nation have historically received federal timber funding. This funding source is expected to end effective July 1, 2008.

In anticipation of the loss of funding, the Douglas County Public Health Division was instructed by the Board of Commissioners to cut the Public Health Division budget by $300,000 for fiscal year 2008-2009. Funding cuts to Public Health in the 2008-2009 budget mean the elimination of 1 Healthy Start position, 2 field staff nurse positions, 1 family planning nurse practitioner, 1 clinic support person, reduction in the Students Today Aren't Ready for Sex (STARS) staffing, reduction in staffing dedicated to health education and population based-services, and the closure of the Public Health Prenatal Clinic.

The Board of Commissioners will contribute County General Fund to the Public Health Division budget to shore up Public Health Services during fiscal year 2008-2009, but the long-term sustainability of Public Health and other county services remains uncertain. In an effort to meet program requirements, the Public Health Division will pursue partnerships and funding opportunities, and will continue to educate the public about the importance of public health.

Douglas County's public health infrastructure has declined over the past several years. Inadequate funding to Public Health continues negatively impact on our ability to provide both basic and other public health services. In fiscal year 2004-2005, the Public Health Division had a budget that supported 64.7 FTE. In fiscal year 2008-2009, the Public Health Division will have an expected staffing of 49.8 FTE. With a reduction in staff comes a reduction in services, reduction in revenue, and a reduction in matching funds. The Public Health Division is cutting approximately $300,000 from its 2008-2009 budget. A cut of this magnitude has had and will continue to have a far-reaching impact on all Public Health Programs and the health of our community.

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

b. Substance Abuse
A public health priority in Douglas County, and all communities, is the substance abuse—including tobacco, alcohol, prescription drug abuse, methamphetamine and other and other illegal drug use. Substance abuse during pregnancy, among youth, and adults is widespread and takes a huge toll on entire communities. Budget cuts to the Douglas County Public Health Division and to Public Health throughout Oregon will further dismantle upstream efforts to prevent substance abuse and its costs and consequences. Funding decisions must be reprioritized and redirected to prevent the conditions that lead to substance abuse. The Public Health Division will continue to provide staff support and expertise to local efforts to address the problem of substance abuse in Douglas County.

c. Inadequate Public Transportation
Douglas County is geographically larger than the state of Connecticut. The vast majority of health and social services are located in the City of Roseburg core area. At best, mobility services in Douglas County are uneven. Although special transportation needs generally far outstrip current capacity and funding, and are often affected by geographic barriers, some needs are better served than others. For example, unmet mobility needs are greatest in the smaller towns and unincorporated rural areas of the County where transportation service is limited or nonexistent. However, more of those needs are being met in the Roseburg area, which is served by three public transit routes and a Dial-a-Ride service. DCHSS has run the local Umpqua Transit bus system since 2006, but as of the 2007-2008 budget will not. Douglas County is currently in the process of making a decision of who to turn the Umpqua Transit bus system over to.

d. Urgent Care as Primary Care.
Non-urgent use of emergency rooms is an indicator of a growing public health concern. When hospital emergency rooms and urgent care clinics are used for primary care, recipients of care do not receive efficient, coordinated and continuous care. Those who rely on emergency rooms for primary care are typically those who are most at risk of poor physical, oral, and mental health—uninsured, underinsured children, pregnant women, adults, and the elderly. Budget cuts to public health services for uninsured and underinsured residents guarantee an increase in non-urgent emergency room visits and a corresponding increase in costs to taxpayers.

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

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

VI. Budget

The Douglas County Health and Social Services budget planning for Fiscal Year 2008-2009 is currently in progress. Final approval will come prior to June 30, 2008. DHS can obtain a copy of the budget document from the following contact:

Douglas County Health and Social Services
Attention: Marsha Price, Management Analyst
621 West Madrone
Roseburg, OR 97470
(541) 440 – 3613

VII. Minimum Standards

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

Organization

1. Yes _X__ No ___ A Local Health Authority exists which has accepted the legal responsibilities for public health as defined by Oregon Law.

2. Yes _X__ No ___ The Local Health Authority meets at least annually to address public health concerns.

3. Yes _X__ 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 _X__ No ___ Current local health department policies and procedures exist which are reviewed at least annually.

5. Yes _X__ No ___ Ongoing community assessment is performed to analyze and evaluate community data.

6. Yes _X__ No ___ Written plans are developed with problem statements, objectives, activities, projected services, and evaluation criteria.

7. Yes _X__ No ___ Local health officials develop and manage an annual operating budget.

8. Yes _X__ No ___ Generally accepted public accounting practices are used for managing funds.

9. Yes _X__ No ___ All revenues generated from public health services are allocated to public health programs.

10. Yes _X__ No ___ Written personnel policies and procedures are in compliance with federal and state laws and regulations.

11. Yes _X__ No ___ Personnel policies and procedures are available for all employees.

12. Yes _X__ No ___ All positions have written job descriptions, including minimum qualifications.

13. Yes _X__ No ___ Written performance evaluations are done annually.

14. Yes _X__ No ___ Evidence of staff development activities exists.

15. Yes _X__ No ___ Personnel records for all terminated employees are retained consistently with State Archives rules.

16. Yes _X__ No ___ Records include minimum information required by each program.

17. Yes _X__ No ___ A records manual of all forms used is reviewed annually.

18. Yes _X__ No ___ There is a written policy for maintaining confidentiality of all client records which includes guidelines for release of client information.

19. Yes _X__ No ___ Filing and retrieval of health records follow written procedures.

20. Yes _X__ No ___ Retention and destruction of records follow written procedures and are consistent with State Archives rules.

21. Yes _X__ No ___ Local health department telephone numbers and facilities' addresses are publicized.

22. Yes _X__ No ___ Health information and referral services are available during regular business hours.

23. Yes _X__ 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 _X__ 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 _X__ No ___ To preserve the confidentiality and security of non-public abstracts, all vital records and all accompanying documents are maintained.

26. Yes _X__ No ___ Certified copies of registered birth and death certificates are issued within one working day of request.

27. Yes _X__ 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 _X__ No ___ A system to obtain reports of deaths of public health significance is in place.

29. Yes _X__ 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 _X__ No ___ Health department administration and county medical examiner review collaborative efforts at least annually.

31. Yes _X__ No ___ Staff is knowledgeable of and has participated in the development of the county's emergency plan.

32. Yes _X__ No ___ Written policies and procedures exist to guide staff in responding to an emergency.

33. Yes _X__ No ___ Staff participate periodically in emergency preparedness exercises and upgrade response plans accordingly.

34. Yes _X__ No ___ Written policies and procedures exist to guide staff and volunteers in maintaining appropriate confidentiality standards.

35. Yes _X__ No ___ Confidentiality training is included in new employee orientation. Staff includes: employees, both permanent and temporary, volunteers, translators, and any other party in contact with clients, services or information. Staff sign confidentiality statements when hired and at least annually thereafter.

36. Yes _X__ No ___ A Client Grievance Procedure is in place with resultant staff training and input to assure that there is a mechanism to address client and staff concerns.

Control of Communicable Diseases

37. Yes _X__ No ___ There is a mechanism for reporting communicable disease cases to the health department.

38. Yes _X__ No ___ Investigations of reportable conditions and communicable disease cases are conducted, control measures are carried out, investigation report forms are completed and submitted in the manner and time frame specified for the particular disease in the Oregon Communicable Disease Guidelines.

39. Yes ___ No _X_ Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or communicable disease case received.

40. Yes _X__ 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 _X__ 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 _X__ No ___ There is a mechanism for reporting and following up on zoonotic diseases to the local health department.

43. Yes _X__ No ___ A system exists for the surveillance and analysis of the incidence and prevalence of communicable diseases.

44. Yes _X__ 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 _X__ No ___ Immunizations for human target populations are available within the local health department jurisdiction.

46. Yes _X__ No ___ Rabies immunizations for animal target populations are available within the local health department jurisdiction.

Environmental Health

47. Yes _X__ No ___ Food service facilities are licensed and inspected as required by Chapter 333 Division 12, or more frequently based on epidemiological risk.

48. Yes _X__ No ___ Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.

49. Yes _X__ No ___ Training in first aid for choking is available for food service workers.

50. Yes _X__ No ___ Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided.

51. Yes _X__ No ___ Each drinking water system conducts water quality monitoring and maintains testing frequencies based on the size and classification of system.

52. Yes _X__ No ___ Each drinking water system is monitored for compliance with applicable standards based on system size, type, and epidemiological risk.

53. Yes _X__ No ___ Compliance assistance is provided to public water systems that violate requirements.

54. Yes _X__ No ___ All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken.

55. Yes _X__ No ___ A written plan exists for responding to emergencies involving public water systems.

56. Yes _X__ No ___ Information for developing a safe water supply is available to people using on-site individual wells and springs.

57. Yes _X__ No ___ A program exists to monitor, issue permits, and inspect on-site sewage disposal systems.

58. Yes _X__ No ___ Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.

59. Yes _X__ No ___ School and public facilities food service operations are inspected for health and safety risks.

60. Yes _X__ 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 _X__ No ___ A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste.

62. Yes _X__ No ___ Indoor clean air complaints in licensed facilities are investigated.

63. Yes _X__ No ___ Environmental contamination potentially impacting public health or the environment is investigated.

64. Yes _X__ No ___ The health and safety of the public is being protected through hazardous incidence investigation and response.

65. Yes _X__ No ___ Emergency environmental health and sanitation are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control.

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

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

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

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

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

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

Nutrition

73. Yes _X__ 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 _X__ No ___ WIC
    b. Yes _X__ No ___ Family Planning
    c. Yes _X__ No ___ Parent and Child Health
    d. Yes ____ No _X_ Older Adult Health
    e. Yes ___ No ____ NA __X___ Corrections Health

75. Yes _X__ No ___ Clients identified at nutritional risk are provided with or referred for appropriate interventions.

76. Yes _X__ No ___ Culturally and linguistically appropriate nutritional education and promotion materials and methods are integrated within programs.

77. Yes _X__ No ___ Local health department supports continuing education and training of staff to provide effective nutritional education.

Older Adult Health

78. Yes ___ No _X_ Health department provides or refers to services that promote detecting chronic diseases and preventing their complications.

79. Yes _X__ No ___ A mechanism exists for intervening where there is reported elder abuse or neglect.

80. Yes _X__ 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 _X_ Prevention-oriented services exist for self health care, stress management, nutrition, exercise, medication use, maintaining activities of daily living, injury prevention and safety education.

Parent and Child Health

82. Yes _X__ No ___ Perinatal care is provided directly or by referral.

83. Yes _X__ No ___ Immunizations are provided for infants, children, adolescents and adults either directly or by referral.

84. Yes _X__ No ___ Comprehensive family planning services are provided directly or by referral.

85. Yes _X__ 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 _X__ No ___ Child abuse prevention and treatment services are provided directly or by referral.

87. Yes _X__ No ___ There is a system or mechanism in place to assure participation in multi-disciplinary teams addressing abuse and domestic violence.

88. Yes _X__ No ___ There is a system in place for identifying and following up on high risk infants.

89. Yes _X__ No ___ There is a system in place to follow up on all reported SIDS deaths.

90. Yes _X__ No ___ Preventive oral health services are provided directly or by referral.

91. Yes _X__ No ___ Use of fluoride is promoted, either through water fluoridation or use of fluoride mouth rinse or tablets.

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

Primary Health Care

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

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

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

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

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

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

Cultural Competency

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

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

102. Yes _X__ 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 _X__ The local health department Health Administrator meets minimum qualifications:

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.

Douglas County is a Safety Net County. Therefore, the funding available for Public Health has decreased while the need for the Administrator to be in the office has intensified. Funding restrictions does not make it possible for the Administrator to begin a program at this time. When the funding crisis eases, she will be able to reconsider a program.

104. Yes _X__ 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 _X__ 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.

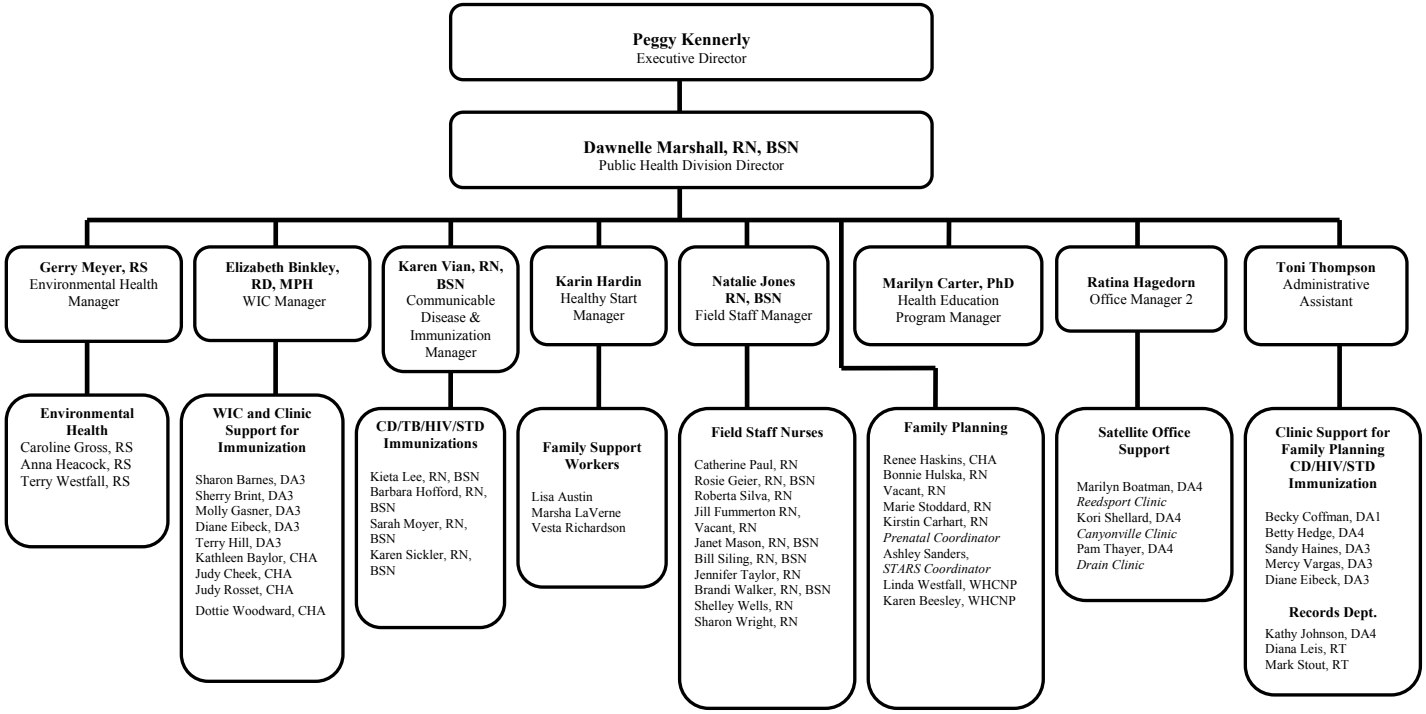
106. Yes _X__ No ___ The local health department Health Officer meets minimum qualifications:

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 the Annual Plan pursuant to ORS 431.385, and assures that the activities defined in ORS 431-375-431.385 and ORS 431.416, are performed.

Douglas County Health and Social Services	Douglas County	May 1, 2008
Local Public Health Authority	County	Date

Douglas County Health & Social Services
Organizational Chart
May 2008



Douglas County
PUBLIC HEALTH DIVISION
Organizational Chart

Immunization Annual Plan Objectives FY 2006

Plan A - Continuous Quality Improvement:
4th DTaP rate, missed shots rate, invalid Hepatitis B doses with local health department

Year 1: July 2005 – June 2006				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results[1]	Progress Notes[2]
A. Implement a plan to increase the 4th DTaP rate in the LHD by 10% over 3 years	• Advocate with DHS that change will occur when/if CDC moves the 4th DTaP on the childhood immunization schedule • Survey clinical staff for timing of 4th DTaP • Advocate for ALERT Registry to do 4th DTaP recall for Douglas County • Assess children in the 2004 AFIX cohort for timing of 4th DTaP • Program manager to attend 4th DTaP	• Yearly 4th DTaP recall postcards sent by ALERT Registry to target populations • 4th DTaP rate will increase by 3% Marketing materials will be distributed by December 2005	• Immunization program manager and 3 immunization staff attended 2005 Oregon Immunization Conf. • Immunization nurse and 4 reception staff attended 2006 Oregon Immunization Conf. • 4th DTaP CD summary distributed to health dept staff Sept 2005 • 807 4th DTaP postcard recalls generated by ALERT mailed October 2005. Postcard criteria: all kids submitted by Douglas County HD, born 9/1/2000 - 8/31/2004, with fewer	• Successes – ALERT postcard recall/reminders to targeted populations appear to be an easy, inexpensive method to contact children lacking 4th DTaP. In Oct-Dec 2005, the LHD gave 407 DTaP, in Oct-Dec 2006 the LHD gave 455 DTaP; statewide campaign for immunization promotion is appropriate use of resources to improve public health outcomes • Challenges - Attempted to establish billboard in Roseburg; however, vendor has not followed-through with request for additional

1 **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
2 **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

	education session at 2005 Immunization Conference • Distribute 4th DTaP marketing materials, as received to child care facilities, Child Health clinic, WIC, home visit nurses, as appropriate • Educate clinical staff on the 4th DTaP marketing plan and to move 4th DTaP up to as early as 12 months of age, as able		than four doses of DTaP recorded in ALERT • 4th DTaP media cards mailed to 26 preschools and daycares • 4th DTaP posters and media cards distributed to health dept clinics December 2005 • 4th DTaP article in health dept quarterly health report Jan 2006 • 4th DTaP radio PSAs emailed to 5 radio stations in Feb 2006 • 4th DTaP rate increased to 70.8% in 2005 assessment, from 66.3% in 2004 assessment • Timing of 4th DTaP rate has not changed substantially when comparing 2004 and 2005 graphs. Timing of 3rd DTaP has improved from 8 mo of age to 7 mo of age. • Newly hired nurses viewed CDC 4-part videos	information. Subjective survey of LHD staff in summer 2005 found staff asking for written direction from state staff regarding moving 4th DTaP to 12 months (if 6 months has passed since 3rd DTaP), when it appears on childhood immunization schedule from 15 to 18 months of age. Most clinic staff giving 4th DTaP at 15 to 18 months of age. Recommend to state that timing of 4th DTaP graph be included in AFIX reports. It remains unknown if radio stations played 4th DTaP PSAs and if so, how many times.

B. Implement a plan to reduce the missed shots rate in the LHD by 2% over 3yrs	• Assess children in 2004 AFIX cohort that constitute missed shots for trends • Assess policy and consistency of screening children for needed shots • Educate staff on missed shots rate in LHD practice • Share strategies to improve missed opportunity rate • Encourage clinical staff to view CDC satellite/web cast broadcasts on immunizations	• **Review children in 2004 AFIX cohort that constitute missed shots by July 2005** • Provide feedback of review to AFIX by August 2005 • Provide feedback of review to clinic staff by September 2005 • Document 80% of clinical staff trained in TRUE contraindications	• Received and reviewed list of children in 2004 AFIX cohort that constituted missed shots • Provided feedback of review of missed shots in AFIX assessment with Nathan by email • Email sent in 2005 to health dept staff to remind about missed shot opportunities • Health dept staff attended 2005 and 2006 CDC immunization web casts • Missed shots rate increased slightly at 7.8% in 2005 AFIX assessment, from 6.6% in 2004 AFIX assessment • Newly hired nurses viewed CDC 4-part videos • Immunization nurse and 4 reception staff attended 2006 Oregon Immunization Conf.	• Successes – feedback from ALERT regarding listing of missed shots has been helpful quality assurance for the county's self-automated immunization database • Challenges – The childhood immunization schedule, varied manufacturers, varied combination vaccines & newly approved vaccines contribute to a potential for missed shot opportunities. The AFIX report is not a timely way to evaluate vaccine administration and correct clinic or nurse practices. Could ALERT generate monthly quality assurance reports regarding missed shots, invalid Hep B doses, etc that evaluate recently given immunizations?

C. Implement a plan to decrease the number of invalid Hep B doses in the LHD over 3yrs as measured by Figure 9 in the AFIX assessment	• Survey clinical staff for timing of Hep B doses • Review each ALERT recall/reminder list for trends •Assess children in the 2004 AFIX cohort for trends in invalid Hep B doses •Educate clinical staff on reasons for invalid Hep B doses	• **Review children in ALERT recall/reminder list that constitute invalid Hep B doses** • Provide feedback of review to AFIX by August 2005 • Provide feedback of review to clinic staff by September 2005 • Invalid Hep B doses will decrease as measured by Figure 9 in the 2005 AFIX assessment • Invalid Hep B doses will decrease as measured by the number of occurrences noted on the ALERT recall/reminder lists	• Monthly ALERT 26 mo cohort recall/reminder list subjectively evaluated, invalid Hep B doses have decreased as data quality has improved • ALERT program unable to generate listing of children with invalid Hep B doses that were included in AFIX cohort • In 2004, 74% of 2 yr olds were fully immunized with 3 valid doses of HepB. In 2005, that rate jumped to 86% fully immunized with 3 doses of valid HepB. An email of 07/18/06 from Nathan Crawford/AFIX states only a 2% invalid dose rate for Hep B in 2005. • Newly hired nurses viewed CDC 4-part videos	• Successes – met the goal of decreasing the invalid Hep B doses. Will continue this objective for the next 2 plan years, but only to maintain this objective. • Challenges – The AFIX report is not a timely way to evaluate vaccine administration and correct clinic or nurse practices. Could ALERT generate monthly quality assurance reports regarding missed shots, invalid Hep B doses, etc that evaluate recently given immunizations?

Plan A - Continuous Quality Improvement:
4th DTaP rate, missed shots rate, invalid Hepatitis B doses with local health department

Year 2: July 2006 – June 2007				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results[1]**	**Progress Notes[2]**
A. **Increase the 4th DTaP rate in the LHD by 10% over 3 years**	• Assess children in the 2005 and/or 2006 AFIX cohort for timing of 4th DTaP • Educate staff on progress of 4th DTaP plan • Refresh staff on 4th DTaP schedule • Encourage clinical staff to view CDC satellite & web cast broadcasts on immunizations • Will distribute radio files to area radio stations	• Yearly 4th DTaP recall postcards sent by ALERT Registry to target populations • 4th DTaP rate will increase by 3% • Decide efficacy of continuing plan in the next year	• Immunization program manager, one nurse practitioner, two nurses, and three reception staff attended 2007 NW Immunization Conf. • Completed post card recalls for late starters October 2006 with feedback to DHS • Completed post card recalls for inadequate Hep A doses February – May 2007 • Evaluated missed shots report from annual AFIX assessment February 2007 with feedback to DHS • 4th DTaP billboard posted September – October 2006 on Garden Valley Blvd. in Roseburg, OR • 4th DTaP rate decreased to 65% in 2006 AFIX assessment; was 70.8% in	Successes – ALERT postcard recalls to targeted populations appear to be an easy, inexpensive method to contact children lacking immunizations; however, there is a high rate of returned postcards. Hopefully, targeting a recall towards one particular vaccine has a subsequent effect of affecting other vaccine rates. Challenges – After much work, established a 4th DTaP billboard in Roseburg; however, vendor initially placed it next to a billboard advertisement for alcohol. Most clinic staff giving 4th DTaP at 15 to 18 months of age as this follows the recommended timing described on the CDCs immunization table. Recommend to state program that timing of 4th DTaP

1 **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
2 **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

			2005 assessment & 66.3% in 2004 assessment • Immunization banner hung on Roseburg health dept building June, July & Aug 2006 • Back-to-school reminder on reader board one week in August 2006 • Timing of 4th DTaP rate appears to be slowly changing substantially when comparing 2004, 2005, and 2006 graphs. Timing of 3rd DTaP has improved from 8 mo of age in 2004 to 7 mo of age in 2005 and 2006. It appears that more children are getting their 4th DTaP at 13, 14, and 15 months of age than previously in 2004 and 2005. • Newly hired nurses viewed CDC 4-part web cast training	graph be included automatically in AFIX reports.
B. **Reduce missed shot rate in the LHD by 2% (or more) over 3 years**	• Assess children in 2005 AFIX cohort that constitute missed shots for trends • Educate staff on missed shots rate in LHD practice • Encourage clinical staff to view CDC	• Missed shots rate decreased by 1% • Decide efficacy of continuing plan in the next year	• Received and reviewed list of children in 2006 AFIX cohort that constituted missed shots • Provided feedback of review of missed shots in AFIX assessment with state by email in February 2007 • Health dept staff attended 2007 CDC immunization web casts • Missed shots rate increased	Successes – feedback from ALERT regarding listing of missed shots has been helpful quality assurance for the county's self-automated immunization database. Program has learned from review of missed shot report that multiple things affect the missed shot rate: birth dose Hep Bs, one time only clients,

	satellite/web cast broadcasts on immunizations		to 13% in 2006 AFIX assessment. Rate was 7.8% in 2005 and 6.6% in 2004 AFIX assessment (2006 missed shot rate was calculated based on if the child received ANY shot that day, rather than if they received at least one shot from the 4:3:1:3:3 series). • Immunization program manager, one nurse practitioner, two nurses, and 3 reception staff attended the 2007 NW Immunization Conference	kids that have been seen by private and public sector both, clients seen only by private sector but credited to public health. Data collection on local and state level can only improve with this type of QA reviewing. Challenges – The childhood immunization schedule, varied manufacturers, varied combination vaccines & newly approved vaccines contribute to a potential for missed shot opportunities. The AFIX report is not a timely way to evaluate vaccine administration and correct clinic or nurse practices. Could ALERT generate monthly quality assurance reports regarding missed shots, invalid Hep B doses, etc that evaluate recently given immunizations? It is a challenge to compare this year's missed shot rate with last years as they were figured out using different methods.

C. **Increase the number of valid Hep B doses given in the LHD by 6% over 3 years**	• Assess children in the 2006 AFIX cohort for invalid Hep B doses • Educate staff on the progress of invalid Hep B doses • Reassess timing of screening children for needed Hep B doses •	• Invalid Hep B doses will maintain at 5% or below as measured by AFIX assessment	• Monthly ALERT 26 mo cohort recall/reminder list subjectively evaluated, invalid Hep B doses have decreased drastically in the last three years as data quality has improved • ALERT program unable to generate listing of children with invalid Hep B doses that were included in AFIX cohort In 2004, 74% of 2 yr olds were fully immunized with 3 valid doses of HepB. In 2005, that rate jumped to 86% fully immunized with 3 doses of valid HepB. An email of 07/18/06 from Nathan Crawford (AFIX) states only a 2% invalid dose rate for Hep B in 2005. An email of 05/23/07 from Sara Beaudrault (AFIX) states HepB3, valid doses only is at 83%. If counting doses only (without minimum age or minimum spacing requirements): 87%. Therefore a 4% invalid dose rate for Hep B in 2006. • Health dept staff attended 2007 CDC immunization web casts	• Successes – met the goal of maintaining the invalid Hep B doses. Challenges – The AFIX report is not a timely way to evaluate vaccine administration and correct clinic or nurse practices. It would be more beneficial if ALERT or the county had a system that generated monthly quality assurance reports regarding missed shots, invalid Hep B doses, etc that evaluated recently given immunizations.

Plan A - Continuous Quality Improvement:
4th DTaP rate, missed shots rate, invalid Hepatitis B doses with local health department

Year 3: July 2007 – June 2008				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results[1]**	**Progress Notes[2]**
A. **Increase the 4th DTaP rate in the LHD by 10% over 3 years**	• Assess children in the 2006 AFIX cohort for timing of 4th DTaP • Educate staff on the progress of the 4th DTaP marketing plan	• Yearly 4th DTaP recall postcards sent by ALERT Registry to target populations • 4th DTaP rate will increase by 4%	• The 4th DTaP rates are as follows over the course of this 3 year plan: ○ 2004 = 66.3% ○ 2005 = 70.8% ○ 2006 = 65% ○ 2007 = 69% • Written reminder postcards are mailed to birth cohorts in the county • Written reminder postcards are generated through ALERT at 17, 20, and 26 months of age • Written reminder postcards are mailed to all children that came in	• Successes – ALERT postcard recalls to targeted populations appear to be an easy, fairly inexpensive method to contact children lacking immunizations. Targeting a recall towards one particular vaccine has a subsequent effect on other vaccine rates. • Challenges – Did not meet the goal of increasing the 4th DTaP rate by 10% over 3 years. Difficult to assess true progress since method of determining UTD rates

1 **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
2 **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

			for services to remind them of next forecasted immunizations • Completed pediatric Hep A recall in spring 2007 which brings in clients for additional services Timing of 4th DTaP rate appears to be slowly changing substantially when comparing 2004, 2005, and 2006 graphs. Timing of 3rd DTaP has improved from 8 mo of age in 2004 to 7 mo of age in 2005 and 2006. It appears that more children are getting their 4th DTaP at 13, 14, and 15 months of age than previously in 2004 and 2005. It appears that in 2007 we maintained the bulk of 3rd DTaP being given at 7 mo of age. It appears we worsened on the 4th DTaP timing, moving the bulk to the 16 and 17 month timing.	changed in 2006. Biggest challenge is that most staff gives 4th DTaP at 15 to 18 months of age as this follows the recommended timing described on the CDC's immunization table. Recommend to state program that timing of 4th DTaP graph be included automatically in AFIX reports. There is a high rate of returned postcards; an estimated 5 – 15% of postcards can be returned depending on the source of addresses and the last time the child sought immunization services in their lifetime.
B. **Reduce missed**	• Assess children in 2006 AFIX cohort that constitute	• Missed shots rate decreased by 1%	• The missed shot rates are as follows over the course of this 3 year	• Successes – shared 2007 QA of missed shot report with Carlos

shot rate in the LHD by 2% (or more) over 3 years	missed shots for trends • Educate staff on missed shots rate in LHD practice • Encourage clinical staff to view CDC satellite & web cast broadcasts on immunizations		plan: ○ 2004 = 6.6% ○ 2005 = 7.8% ○ 2006 = 13% ○ 2007 = 11% • Received and reviewed list of children in 2006 AFIX cohort that constituted missed shots • Provided feedback of review of missed shots in AFIX assessment with state by email in February 2007	Quintanilla, Albert Koroloff, and Lisa Luna during 2007 AFIX meeting in Douglas County. • Challenges – Did not meet the goal of reducing the missed shot rate by 2% over 3 years. Difficult to assess true progress since method of determining UTD rates changed in 2006. Biggest challenge is that AFIX report is annual feedback and truly need a timelier QA process to provide feedback to staff to change their clinical practice. Also finding of QA revealed that use of Pediarix and birth dose Hep B, caused missed shot to be credited to us. Also found that missed shots given by private providers were credited to us. The childhood immunization schedule, varied manufacturers, varied

				combination vaccines & newly approved vaccines contribute to a potential for missed shot opportunities.
C. **Increase the number of valid Hep B doses given in the LHD by 6% over 3 years**	• Assess children in the 2006 AFIX cohort for invalid Hep B doses • Educate staff on the progress of invalid Hep B doses	• Invalid Hep B doses will maintain at 5% or below as measured by AFIX assessment •	• The valid Hep B rates are as follows over the course of this 3 year plan: ○ 2004 = 74% ○ 2005 = 86% ○ 2006 = 83% ○ 2007 = 89% •	• Success - We met the goal of increasing the valid Hep B rate by 6% over 3 years. AFIX review meeting in our county is a good venue to discuss AFIX rates with frontline staff. • Challenges – Difficult to assess true progress since method of determining UTD rates changed in 2006. Have been informed by state that they are unable to produce a client listing of who are invalid Hep B doses, so QA of this data is limited.

Plan B - Chosen Core Public Health Function Focus Areas:
Douglas County Immunization Coalition, ALERT Promotion in schools

Fiscal Years 2006-2008

• Year 1: July 2005 – June 2006				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results[1]**	**Progress Notes[2]**
A. **The Douglas County Immunization Coalition will meet quarterly**	• Continue to assess local issues • Continue partnerships with local hospitals, school district, OHP, McDonalds, Imagistics, Shots for Tots Committee, community college, physicians, LHD • Coordinate quarterly meetings	• The % of adjusted enrollment in the complete/all category in the 2005-2006 school exclusion process for children's facilities will be 86% or greater • 2005 AFIX assessment will increase to 75% in the coverage rate for the 24 month olds fully covered with the 4:3:1:3:3	• Shots for Tots free Saturday clinic October 2005 • Douglas County Immunization Coalition meeting 10/20/2005 • Shots for Tots free Saturday clinic February 2006 • 1700 recall postcards mailed with assistance of ALERT; recalled cohort of adolescents without 3 Hepatitis B shots in August 2005 • The % of adjusted enrollment in the complete/all category in the 2005-2006 school exclusion process for	• Successes – Twice yearly free Saturday Shots for Tots clinics meet a need in our community for low income and working families. The Shots for Tots community partnership provides a learning venue for nursing students and a marketing opportunity for immunizations. It also takes a load off the health department clinic during school exclusion times. October 2005 – 198 shots given to 90 children. February 2006 – 430 shots given to 187 children. ALERT postcard recall/reminders to targeted

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			children's facilities increased to 91.9% from 84.46% the previous school year • The 2005 AFIX assessment of coverage for the 24 month olds fully covered with 4:3:1:3:3 increased to 77.8%, from 72.1% the year prior • The percent of adjusted enrollment in the complete/all category in the 2005-2006 school exclusion process for 7th graders increased to 98.35%, up from 83.47% the previous year • The percent of adjusted enrollment in the Hep B category in the 2005-2006 school exclusion process for 7th graders increased to 98.85%, up from 86.25% the previous year • The percent of adjusted enrollment in the MMR 2 category in	populations appear to be an easy, inexpensive method to contact children lacking 3 Hepatitis B shots, met initial objective of immunization coverage in 7th graders • Challenges – Shots for Tots is an expensive model to reach the population. The large scale clinic is not convenient for those that live outside of the Roseburg area. The clinic requires great manpower and as adolescents catch up on the MMR2, Hep B, VAR requirements we have seen less children at subsequent clinics.

			the 2005-2006 school exclusion process for 7th graders increased to 99.07%, up from 97.74% the previous year • The percent of adjusted enrollment in the VAR category in the 2005-2006 school exclusion process for 7th graders increased to 98.49%, up from 96.09% the previous year	

B. **The ALERT Registry will be promoted all of the Douglas County child care facilities, Head Starts, public schools, and private schools (abbreviated as schools for the purpose of this document)**	• Assess the level of awareness and use of ALERT in all Douglas County schools	• Reward all school users in Douglas County with a certificate • Request list from DHS of Douglas County schools accessing ALERT through the web • Promotion materials included in school exclusion mailing • Telephone survey by December 2005 of all Douglas County schools inquiring on level of awareness, ease of use, provide with website address, benefits of use, how to get registered to use	• In May 2005, the list of schools in the 2004 AFIX report were telephoned and interviewed. Schools were given verbal praise for ALERT participation and/or the ALERT sign-up process and website were advertised. Corrections to the AFIX report listing were submitted to DHS.	• Successes – county and state collaborated to improve the state's listing of schools using the ALERT website. • Challenges – turnover at schools in both administrators and secretaries makes ongoing use of ALERT difficult to assess. Could ALERT send out to schools & daycares an advertisement about ALERT in August/September annually? Did not mail out certificates to reward users – felt telephone survey of all schools would be more effective use of time.

Plan B - Chosen Core Public Health Function Focus Areas:
Douglas County Immunization Coalition, ALERT Promotion in schools

Year 2: July 2006 – June 2007				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results[1]**	**Progress Notes[2]**
A. **Decrease the number of children excluded from school by 5% over 2 years** **Increase the 4:3:1:3:3 rate by 2% over 2 years**	• Continue to assess local issues • Continue partnerships with community agencies • Coordinate quarterly immunization coalition meetings • Immunization coalition will work on Shots for Tots campaign to help decrease exclusion rate and increase the UTD rate	• The % of adjusted enrollment in the complete/all category in the 2006-2007 school exclusion process for children's facilities will be 87% or greater • 2006 AFIX assessment will increase to 78% in the coverage rate for the 24 month olds fully covered with the 4:3:1:3:3	• Shots for Tots clinic completed February 2007 that served 130 children with 400 shots to bring them into compliance with school exclusion process. • The % of adjusted enrollment in the complete/all category in the 2006-2007 school exclusion process for children's facilities was 94.01% • ALERT sent monthly postcard recalls to three additional subgroups seen at Douglas County Public Health) as part of an effort to change the "W" graph in the AFIX	• Successes – Shots for Tots provides TV, radio, and print media for immunizations. Douglas County is already working on increasing Hep A rates in children less than 5 to prepare for probable 2008-2009 new school requirements. Douglas County collaborates with ALERT to use the data for special postcard recalls. Challenges - It is a challenge to compare this year's AFIX rate with last years as they were figured out using different methods. Coalition met once during 2006, in part due to immunization outreach coordinator taking a new job. Future of ongoing coalition meeting remains uncertain with limited public health funding. Committee remains available

1 **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
2 **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

			report. • 2006 AFIX assessment was 70% coverage rate for the 24 month olds fully covered with the 4:3:1:3:3 (2006 rates were determined by minimum age and spacing criteria rather than counting doses)	for meetings as needed.
B. **Evaluate the plan to promote ALERT in the Douglas County schools**	• Continue to assess the level of awareness and use of ALERT in all Douglas County schools as needed • Request list from DHS of Douglas County schools accessing ALERT through the web to compare number registered, use of ALERT • Promotion materials included in school exclusion mailing	• The # of schools with active web use in the last year will increase by 3 more sites by June 2007. As of July 2006 there are 41 active users out of 57 registered. • The # of childcare facilities with active web use in the last year will increase by 3 more sites by June 2007. As of July 2006 there are 5 active users out of 23 registered.	• As of May 2007 there are 58 schools and 25 childcares that are registered with ALERT. Of these, 48 schools and 7 childcares have used ALERT in 2006 or 2007 to search for immunization histories.	• Successes – Douglas County met the goal of increasing use of ALERT. 7 additional schools and 2 additional childcares are utilizing ALERT over last year. Also, it is convenient for local public health to now monitor utilization of ALERT through the website. Douglas County will continue to remind schools and daycares about ALERT use.

Plan B - Chosen Core Public Health Function Focus Areas:
Douglas County Immunization Coalition, ALERT Promotion in schools

Year 3: July 2007 – June 2008				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results[1]**	**Progress Notes[2]**
A. **Decrease the number of children excluded from school by 5% over 2 years** **Increase the 4:3:1:3:3 rate by 2% over 2 years**	• Immunization coalition will work on Shots for Tots campaign to help decrease exclusion rate and increase the UTD rate • Advocate for ALERT registry reminder/recall postcards to be mailed for 18 month cohort • Nurse to target 7th graders during the 05-06 school year; flyers, assistance in organizing files at middle schools	• The % of adjusted enrollment in the complete/all category in the 2006-2007 school exclusion process for children's facilities will be 88% or greater • 2007 AFIX assessment will increase to 79% in the coverage rate for the 24 month olds fully covered with the 4:3:1:3:3	• The % of adjusted enrollment in the complete/all category in the school exclusion process for children's facilities are as follows over the course of this 3 year plan: ○ 2004/2005 = 84.46% ○ 2005/2006 = 91.9% ○ 2006/2007 = 94.01% ○ 2007/2008 = 94.71% • The AFIX coverage rate for the 24 month olds fully covered with the 4:3:1:3:3 are as follows over the course of this 3 year plan: ○ 2004 = 72.1 % ○ 2005 = 77.8%	• Successes – Douglas County met the goal of decreasing the number of children excluded from school by 5% over 2 years. • Challenges – Douglas County did not meet the goal of increasing the AFIX coverage rate for 24 months covered with 4:3:1:3:3 by 2% over 2 years. Although AFIX is a great snapshot of immunization coverage and an important benchmark to measure, there have been a lot of new immunizations in the last 5 years and

1 **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
2 **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

			○ 2006 = 70% ○ 2007 = 70%	Public Health needs to move to a place where we are state-wide measuring immunization rates across the lifetime.

B. **Evaluate the plan to promote ALERT in the Douglas County schools**	• Continue to assess the level of awareness and use of ALERT in all Douglas County schools as needed • Request list from DHS of Douglas County schools accessing ALERT through the web to compare number registered, use of ALERT • Promotion materials included in school exclusion mailing	• The number of schools with active web use in the last year will increase by 3 more sites by June 2008. • The number of childcare facilities with active web use in the last year will increase by 3 more sites by June 2008.	• The number of schools with active web use are as follows over the course of this 3 year plan: ○ 2004 = unavailable ○ 2005 = obtained list, made corrections to list, marketed ALERT ○ 2006 = 41 of 56 registered ○ 2007 = 46 of 56 registered • The number of childcares with active web use are as follows over the course of this 3 year plan: ○ 2004 = unavailable ○ 2005 = obtained list, made corrections to list, marketed ALERT ○ 2006 = 5 of 23 registered ○ 2007 = 8 of 26 registered	• Successes – Douglas County met the goal of increasing use of ALERT for both the school and childcare facilities. It is convenient for local public health to now monitor utilization of ALERT through the website. Douglas County will continue to remind schools and daycares about ALERT use. • Challenges – turnover of staff and closing and re-opening of certified daycares makes it difficult to stay on top of who is using ALERT regularly.

Outreach Activities: July 2005 – June 2006

Activity 1: Immunization outreach/education to Douglas County				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results[1]**	**Progress Notes[2]**
A. To increase the immunization messages to Douglas County citizens	• Immunization information, clinic hours will be in the DCHSS quarterly Health Report • DCHSS media releases, flyers, targeted campaigns on an as needed basis; e.g. back-to-school shots, flu and pneumonia campaigns, school exclusion, Shots for Tots • DCHSS website will be updated every other month and as needed • DCHSS will research the feasibility of advertising	• The percent of adjusted enrollment in the complete/all category in the 2005-2006 school exclusion process for children's facilities will be 86% or greater • 2005 AFIX assessment will increase to 75% in the coverage rate for the 24 month olds fully covered with the 4:3:1:3:3 • Articles in each of the quarterly Health Reports in 2005-2006 • The DCHSS website will be accessed to the 250	• Back-to-school message on reader board Sept 2005 • Immunization hours and Shots for Tots recap article in health dept quarterly health report October 2005 • Immunization Coalition meeting October 2005 • Flu vaccine message on reader board November 2005 • 4th DTaP article in health dept quarterly health report Jan 2006 • Banner to hang yearly on side of health dept building to promote lifetime immunizations • Staff education with CDC web casts	• Successes –Banner hung June and July 2006. Met initial objective. • Challenges – County requested earlier reminder/recall postcards; however, DHS declined at the time.

1 **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
2 **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

	immunization clinic hours in the local Roseburg paper • Quarterly reader board messages • DCHSS will continue to coordinate the Douglas County Immunization Coalition quarterly meetings • DCHSS will continue to provide satellite Linkage to CDC Broadcasts for private provider opportunity	hit level by April 2005 • Quarterly reader board messages • Quarterly Douglas County Immunization Coalition meetings •	• Health department website updated monthly; immunization page has 281 hits as of January 2006, 384 as of July 2006 • The % of adjusted enrollment in the complete/all category in the 2005-2006 school exclusion process for children's facilities increased to 91.9% from 84.46% the previous school year • The 2005 AFIX assessment of coverage for the 24 month olds fully covered with 4:3:1:3:3 increased to 77.8%, from 72.1% the year prior	

Annual Plan Objectives FY 2008-2009

Year 1: July 2008 – June 2009				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results[3]	Progress Notes[4]
A. Continue to promote and evaluate ALERT in the Douglas County childcares	• Continue to assess the level of awareness and use of ALERT in all Douglas County childcares as needed • Use the listing available on the ALERT website to compare number registered and number actively using ALERT • Promotion materials included in school exclusion mailing • Increasing the childcares actively using ALERT will help reduce the number of school exclusions mailed in	• The number of childcare facilities with active web use in the last year will increase by 5 more sites by December 2008.	• The number of childcares with active web use are as follows: ○ 2004 = unavailable ○ 2005 = marketed ALERT ○ 2006 = 5 of 23 registered ○ 2007 = 8 of 26 registered ○ 2008 = 8 of 26 registered as of 04/15/08) ○ 2008 FINAL STAT TO BE UPDATED IN 2009 ○ 2009 PRELIM STAT TO BE UPDATED IN 2009	• Successes – TO BE UPDATED IN 2009 • Challenges – TO BE UPDATED IN 2009

3 **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

4 **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

	February 2009.			
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results[5]	Progress Notes[6]
B. **The pediatric Hep A and Tdap new school requirements will be promoted in all of the Douglas County certified child care facilities, Head Starts, public schools, private schools, to parents, and media**	• Continue to assess the level of awareness of Hep A and Tdap requirements in all Douglas County schools • Participate in free Tdap state project	• Promotion materials included in school exclusion mailing • Promotion materials included in school back-pack distribution • Promotion materials included in targeted pediatric Hep A reminder postcards to county children 4 and under • Promotion materials included in targeted Tdap reminder postcards to county 6th graders • Promotion materials included in quarterly health report	• TO BE UPDATED IN 2009	• Successes – TO BE UPDATED IN 2009 • Challenges – TO BE UPDATED IN 2009

5 **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

6 **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

		• Promotion materials included in back-to-school registrations • Health Department to work with childcares to increase active users of ALERT • Health Department to work with schools to obtain current mailing addresses so health department can send reminder postcards to targeted populations • Promotion material on free Tdap project will be sent to community partners and media.		

EVALUATION OF WIC NUTRITION EDUCATION PLAN FY 2007-2008

WIC Agency: Douglas County

Person Completing Form: Elizabeth Binkley, WIC Program Manager

Date: April 28, 2008 Phone: (541) 440 – 3546

Return this form, attached to email to: sara.e.sloan@state.or.us by May 1, 2008

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

Goal 1: Oregon WIC staff will have the knowledge to provide quality nutrition education.

Year 1 Objective: During plan period, staff will be able to correctly assess nutrition and dietary risks.

Activity 1: All certifiers will complete the Nutrition Risk Module by December 31, 2007.

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

- Did all certifiers successfully complete all the activities of the Nutrition Risk Module by December 31, 2007?
- Were the completion dates entered into TWIST and the competency achievement checklist filed for each certifier?

Response:

- *All certifier staff have completed the Nutrition Risk Module*
- *The completion dates have been entered into TWIST*

Activity 2: All certifiers will complete the revised Dietary Risk Module by March 31, 2008.

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

- Did all certifiers successfully complete all the activities of the Dietary Risk Module by March 31, 2008?
- Were the completion dates entered into TWIST and the competency achievement checklist filed for each certifier?

Response:

- *No, not all certifier staff has completed the Dietary Risk module. Staff time was limited to work on the module due to the greater need to have appointments for clients in order to maintain caseload.*

- *It is planned for all certifier staff to complete the Dietary Risk Module by April 30, 2008 and the completion dates entered into TWIST.*

Activity 4: Identify your agency training supervisor(s) and staff in-service dates and topics for FY 2007-2008.

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

- Did your agency conduct the staff in-services you identified?
- Were the objectives for each in-service met?
- How do your staff in-services address the core areas of the CPA Competency Model?

Response:

- *Yes, the certifier staff in-services were conducted as outlined in the WIC Staff Training Plan, Activity 4.*

- *Yes, the objectives were met.*

- *The trainings help the certifier staff better understand the skills needed in the role as CPA.*

Goal 2: Nutrition Education offered by the local agency will be appropriate to the clients' needs.

Year 1 Objective: During plan period, each agency will implement strategies to provide targeted, quality nutrition education.

Activity1: Using state provided resources, conduct a needs assessment of your community by September 30, 2007 to determine relevant health concerns and assure that your nutrition education activity offerings meet the needs of your WIC population.

Outcome evaluation: Please address the following questions in your response:

- Was the needs assessment of your community conducted?
- What health concerns did you determine were relevant to your community?
- What did you do with the information you collected?
- Who did you communicate the results of your needs assessment with?

Response:

The assessment of the Nutrition Risk Criteria Prevalence was started but due to time constraints was not completed. The goal is to complete this activity by August 2008.

Activity 2: Complete Activity 2A or 2B depending upon the type of second nutrition education activities your agency offers.

Activity 2A: By October 31, submit an Annual Group Nutrition Education schedule for 2008.

Activity 2B: If your agency does not offer group nutrition education activities, how do you determine 2nd individual nutrition education is appropriate to the clients' needs?

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

- If your agency offers group nutrition education, did you submit your Annual Group Nutrition Schedule for 2008?
- How do you assure that your nutrition education activities meet the needs of your WIC population?

Response:

This Activity was not able to be completed due to time constraints. The goal is to complete this by January 2009.

Goal 3: Improve the health outcomes of WIC clients and WIC staff in the local agency service delivery area.

Year 1 Objective: During plan period, each local agency will develop at least one specific objective and activity to help facilitate healthy behavior change for WIC staff and at least one specific objective and activity to help facilitate healthy behavior change for WIC clients.

Activity 1: Local Agency Objective to facilitate healthy behavior change for WIC staff. Local Agency Staff Activity.

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

- How did your agency decide on this objective and activity?
- Did the activity help meet your objective?
- What went well and what would you do differently?

Response:

- *The WIC staff decided to increase the amount of exercise done on a daily /weekly basis. They had a calendar to record their progress.*

- *Two staff refused to participate; one staff was successful; two staff were partly successful and two staff were not successful in meeting the objective.*

- *Overall it did not seem to go well as something that the staff embraced as important and motivated to do.*

Activity 2: Local Agency Objective to facilitate healthy behavior change for WIC clients. Local agency Client Activity.

Outcome Evaluation: Please address the following questions in your response.
- How did your agency decide on this objective and activity?
- Did the activity help meet your objective?
- What went well and what would you do differently?

Response:

- *Offering a class on promoting fruits and vegetables was decided on as the objective to help clients facilitate healthy behavior change.*

- *Yes, the activity of offering the class met the objective*

- *The class seemed to be enjoyed and well received by the clients.*

Goal 4: Improve breastfeeding outcomes of clients and staff in the local agency service delivery area.

Year 1 Objective: During plan period, each local agency will develop at least one objective and activity to help improve breastfeeding outcomes for WIC staff or WIC clients.

Activity 1: Local Agency Breastfeeding Objective. Local agency Breastfeeding Activity.

Outcome Evaluation: Please address the following questions in your response.
- How did your agency decide on this objective and activity?
- Did the activity help meet your objective?
- What went well and what would you do differently?

Response:

The activity was selected to promote breastfeeding in the workplace.

The Health Department has a designated room set aside exclusively for breastfeeding mothers.

What we would like to complete is the application toward having the designation of the Douglas County Health Department being a "Breastfeeding Friendly Employer."

FY 2008 - 2009 WIC Nutrition Education Plan

County/Agency:	***Douglas County***
Person Completing Form:	***Elizabeth Binkley, MS, RD - WIC Program Manager***
Date:	***April 28, 2008***
Phone Number:	***(541) 440 - 3546***
Email Address:	***ehbinkle@co.douglas.or.us***

Return this form electronically (attached to email) to: sara.e.sloan@state.or.us
by May 1, 2008
Sara Sloan, 971-673-0043

Goal 1: Oregon WIC Staff will have the knowledge to provide quality nutrition education.

Year 2 Objective: During plan period, through informal discussions, staff in-services and/or targeted trainings, staff will be able to describe the general content of the new WIC food packages and begin to connect how these changes may influence current nutrition education messages.

Activity 1:

By October 31, 2008, staff will review the Oregon WIC Key Nutrition Messages and identify which one's they need additional training on.

Resources: American Academy of Pediatrics, MyPyramid.gov, Maternal and Child Health Oral health website –

http://www.mchoralhealth.org/Openwide/ Information from the 2008 WIC Statewide meeting.

Implementation Plan and Timeline:

During our July 2008 staff meeting, we will review the Oregon WIC Key Nutrition Messages and identify the one's staff need additional clarification on. For those messages that need clarification, our training supervisor will then prepare additional information to share with staff at our September staff meeting.

Activity 2:

By March 31, 2009, staff will review the proposed food packages changes and:

- Select at least three food packages modifications (for example, addition of new foods, reduction of current foods, elimination of current foods for a specific category),
- Review current nutrition education messages most closely connected to those modifications, and
- Determine which messages will remain the same and which messages may need to be modified to clarify WIC's reasoning for the change and/or reduce client resistance to the change.

Resources: WIC Works Website WIC food package materials, Information from the 2008 WIC Statewide meeting, State provided materials.

Implementation Plan and Timeline:

In January 2009, we will begin to share WIC food package resource information with all staff such as the "WIC Food Packages…Time for a Change" on the WIC Works website. We will review the Fresh Choices 2009 Status Report updates. At our February 2009 staff meeting, we will discuss the food packages modifications and how they "fit" with our education messages.

Activity 3:

Identify your agency training supervisor(s) and projected staff in-service training dates and topics for FY 2008-2009. Complete and return Attachment A by May 1, 2008.

***Training Supervisor*:** *Elizabeth Binkley, MS, RD*

Goal 2: Nutrition Education offered by the local agency will be appropriate to the clients' needs.

Year 2 Objective: During Plan period, each agency will assess staff knowledge and skill level to identify areas of training needed to provide participant centered services.

Activity 1:

By September 30, 2008, staff will review the diet assessment steps from the Dietary Risk Module and identify which ones they need additional training on.

Resources include: State provided guidance and assessment tool.

Implementation Plan and Timeline:

In September we will use the state provided guidance and assessment tool to identify which steps from the Dietary Risk Module staff need

additional training and or practice with. Our training supervisor/coordinator will take the assessment results and provide training on these steps at our November staff meeting.

Activity 2: By November 30, 2008, staff will evaluate how they have modified their approach to individual counseling after completing the Nutrition Risk and Dietary Risk Modules.

Resources include: State provided guidance and assessment tools.

Implementation Plan and Timeline:

During our staff meeting in November, staff will share how they have modified their approach to individual counseling after completing the Nutrition Risk and Dietary Modules. We plan to have staff observe each other for the next several months and provide feed back.

Goal 3: Improve the health outcomes of clients and staff in the local agency service delivery area.

Year 2 Objective: During Plan period, in order to help facilitate healthy behavior change for WIC staff and WIC clients, each local agency will select at least one objective and implement at least one strategy from the Statewide Physical Activity and Nutrition Plan 2007-2012.

Activity 1:

Identify your setting, objective and strategy to facilitate healthy behavior change for WIC staff.

Setting: *Worksite*

Objective: *By 2012, increase the number of WIC staff who establish a regular exercise program 30*

minutes a day, at least 5 days a week.

Strategy: *Provide staff information that promotes physical activity and discuss with staff who are participating ideas that may help them meet their goal.*

Resource: Attachment B - A Healthy Active Oregon: Statewide Physical Activity and Nutrition Plan 2007-2012, Recommended Objectives and Strategies

Implementation Plan and Timeline: Include why this objective was chosen, what you hope to change, how and when you will implement the strategy, and how you will evaluate its effectiveness.

We chose this objective to build on last year's goal for WIC staff to increase their physical activity. Staff now wants to work on establishing a regular exercise program. In the nutrition classes on fitness that staff teaches, they want to model healthy behaviors for the clients and also to improve their personal health.

Activity 2:

Identify your setting, objective and strategy to facilitate healthy behavior change for WIC clients.

Setting: *Home/ Household*

Objective: *By 2012, decrease television and other screen time for children. Reduce the number of children ages 2 to 5 who have more than two hours of screen time and work to reduce the number of children 2 years and younger to have no screen time.*

Strategy: *Encourage WIC families to participate in TV-Turnoff Week each year and meet the American Academy of Pediatrics screen time recommendations throughout the year. Also encourage alternatives to television and screen time, by promoting activity rooms in place of media rooms.*

Resource: Attachment B - A Healthy Active Oregon: Statewide Physical Activity and Nutrition Plan 2007-2012, Recommended Objectives and Strategies

Implementation Plan and Timeline: Include why this objective was chosen, what you hope to change, how and when you will implement the strategy, and how you will evaluate its effectiveness.

We chose this objective because we are aware of the effects excessive screen time and physical inactivity has on children and their family. We want to encourage families to be physically active to help reduce obesity. What we hope to change is to increase parents' awareness about the effects of excessive screen time. We also hope to change the amount of time that families are active, by encouraging them to increase it.

How we will implement this strategy is to promote the importance of physical activity in individual certification appointments and to promote the classes the WIC offers that present information about the importance of physical activity.

We will evaluate our strategy by surveying participants in July 2008 to ask about their physical activity and then in March 2009 survey clients again to find out if any changes have been made to the amount of time family members watch TV and the amount of time they are physically active.

Goal 4: Improve breastfeeding outcomes of clients and staff in the local agency service delivery area.

Year 1 Objective: During Plan period, in order to help improve breastfeeding outcomes for WIC participants, each local agency will select at least one setting, objective and implement at least one strategy from the Statewide Physical Activity and Nutrition Plan 2007-2012.

Resource: Attachment B - A Healthy Active Oregon: Statewide Physical Activity and Nutrition Plan 2007-2012, Recommended Objectives and Strategies

Activity 1:

Setting: *Health Care/Community*

Objective: *To increase support for breastfeeding and work toward development of a breastfeeding partnership with the local hospital in Roseburg.*

Strategy: *To discuss with the State WIC Lactation/Breastfeeding Coordinator ways to develop a relationship with the local hospital to have WIC breast pumps available for mothers who are in urgent need of a breast pump to support their breastfeeding efforts.*

Implementation Plan and Timeline: Include why this objective was chosen, what you hope to change, how and when you will implement the strategy, and how you will evaluate its effectiveness.

The objective was chosen to increase breastfeeding duration, to support mothers who are having difficulty breastfeeding their infant(s) and to work toward the development of a community partnership with the local hospital so that breast pumps can be available to WIC mothers who have an immediate need to pump.

We hope to change the current situation of breast pumps not being readily available to moms who have an urgent need.

How we will implement this strategy is the WIC Coordinator will ask for a conference call with the State WIC Lactation/Breastfeeding Coordinator and the State Nutritionist assigned to our local agency to explore ways to approach the local hospital to build a working relationship.

The strategy will be implemented by July 2008.

We will evaluate the effectiveness of our objective by how successful the partnership is developed and implemented.

Activity 2:

We hope to continue to work toward to the goal of having the Douglas County Health Department apply to be a "Breastfeeding Friendly Employer." The Health Department has a room available for Breastfeeding mothers but has not completed the steps to apply for being a "Breastfeeding Friendly Employer."

Attachment A

FY 2008-2009 WIC Nutrition Education Plan

Goal 1, Activity 3

WIC Staff Training Plan – 7/1/2008 through 6/30/2009

Agency: *Douglas County*
Training Supervisor(s) and Credentials: *Elizabeth Binkley MS, RD*

Staff Development Planned

Based on planned new program initiatives (for example Oregon WIC Listens, new WIC food packages), your program goals, or identified staff needs, what quarterly in-services and or continuing education are planned for existing staff? List the in-services and an objective for quarterly in-services that you plan for July 1, 2008 – June 30, 2009. State provided in-services, trainings and meetings can be included as appropriate.

Quarter	Month	In-Service Topic	In-Service Objective
1	August September	Oregon WIC Listens Oregon WIC Key Nutrition Messages	Review with certifier staff the "Oregon WIC Listens" educational objectives Provide clarification on Oregon State WIC " Key Nutrition Messages"
2	November	Dietary Risk Module	Provide certifier additional training on dietary risks as determined by staff assessment
3	January February	Oregon WIC Listens Fresh Choices	Continue to review with staff and assess training needs Discuss the new food package modifications and how they fit the WIC nutrition message.
4	April	New WIC Food Packages Screens	Provide training on the new TWIST screens and assess the areas that staff may need additional assistant using the new food package screens