2016 Stanislaus County Public Health Annual Report

Presented July 2016 to the

Board of Supervisors

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Foreword

It gives us great pleasure to present the 2016 Health Services Agency/Public Health Division (HSA/PH) Annual Report for Stanislaus County. The report documents Public Health's recent actions and commitments to the residents of this community in achieving our vision of "*Healthy People in a Healthy Stanislaus*!" through the values of 'Quality, Efficiency, Compassion, Ethics, Sustainability, Cultural Sensitivity, Dedication, Accountability, and Transparency'.

This and future reports will highlight our accomplishments as they align with the nationally recognized **10 Essential Public Health Services**, which serve as a best practice and road map for achieving Public Health Accreditation in 2017-2018.

Public Health Core Functions and Essential Services

2015 was the year for change implementation. One of the main accomplishments for the HSA/PH Division was completing the strategic plan to align with the overall HSA 3-year strategic plan and build on the Board's priorities of 1) a healthy community, 2) efficient delivery of services, and 3) establishing effective partnerships. The development of this document helps ensure that HSA/PH sets strategic priorities aligned with federal, state, and local initiatives, as well as maintains a competent public health workforce that can effectively engage the citizens of Stanislaus County.

The support of the Board of Supervisors (BOS) is very much appreciated, as they join with HSA/PH and its many partners as we strive to improve the health and well-being of all residents.

Sincerely,

John Walker, MD
Public Health Officer

Rebecca Nanyonjo-Kemp, DrPH
Public Health Director

The Purpose of Public Health

The World Health Organization (WHO) defines the term public health as "all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole." Health is defined holistically as:

> *…a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."*
>
> *World Health Organization, 1948*

While the above is an appropriate representation of the overarching responsibility of public health as a discipline, these annual reports represent a significant opportunity in offering ongoing clarification of public health's goals, objectives, and its role within the community. The Centers for Disease Control and Prevention (CDC) defines the fundamental obligation of population-based health (public health) to:

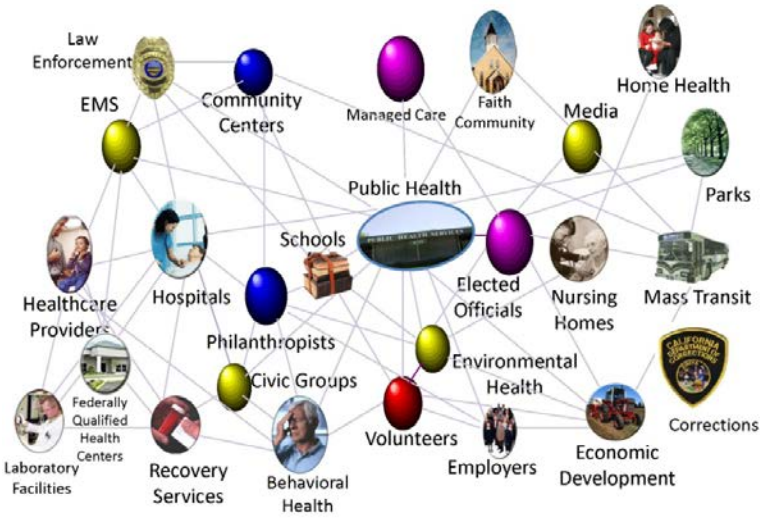
- Prevent epidemics and spread of disease
- Protect against environmental hazards
- Promote and encourage healthy behaviors and mental health
- Prevent injuries
- Respond to disasters and assist communities in recovery
- Assure the quality and accessibility of health services

These responsibilities describe and define the function of public health – through community/population-wide prevention, promotion, and protection. Many of public health services are not obvious to the general public until the need arises for intervention. The practice of public health is met through alignment with the 10 Essential Public Health Services, which have been presented in previous reports and will continue to serve as a cornerstone for subsequent annual reports.

According to NACCHO (The National Association of City and County Health Officials), the US public health system is composed of a web of public and private partners; led and coordinated by the public health department (Figure 1). The success of public health initiatives and programs relies on key partnerships, including those with hospitals, behavioral health, community services, private nonprofits, businesses, physicians, etc. – with the goal of optimizing individual and community health and well-being. Removing obstacles to achieving health and well-being cannot fall under the purview of one single agency.

Achieving better community outcomes requires a multi-disciplinary approach. In short, public health is a shared responsibility.

Figure 1: The US Public Health System



Progress in 2015

Achievements

The HSA/Public Health Division (HSA/PH) continues to undergo strategic and operational changes. In 2015, two new positions were filled, the Public Health Manager IV/Public Information Officer (PIO) and Accreditation Coordinator. This resulted in greater support in establishing initiatives and priorities adopted the previous year. This included submitting a formal application for accreditation through the national Public Health Accreditation Board (PHAB) and the improved coordination of the following program areas: Health Promotion & Nutrition; Emergency Preparedness; PH Laboratory; and Community Assessment Evaluation and Planning (CAPE), as well as addressing the need of a PIO following the retirement of the HSA Assistant Director who served in that capacity.

Also in 2015, the HSA/PH Division completed its three-year (3 yr.) strategic plan and, as part of that process, developed the following mission statement:

Mission of Public Health

Through leadership, teamwork, continuous quality improvement, ensuring a competent workforce and implementing best practices

Prevent illness and injury through ongoing community assessment, monitoring, and evaluation;

Promote wellness and healthy lifestyles through community engagement, public education, development of policies and plans, and improve access through assuring linkages to care; and

Protect the public through disease investigation, enforcement of public health laws, preparation for and response to emergencies.

Challenges

HSA/PH has been challenged by the loss of institutional knowledge with multiple retirements in 2015 and many expected in 2016. The workforce is further impacted with new professionals remaining with the county for an abbreviated tenure, making the PH Division essentially serve as a professional training academy for surrounding counties and institutions. Significant issues also persist in the recruitment and retention of key licensed/professional personnel which are required for many programs and services throughout HSA. Several key positions have been vacant for two or more years, affecting services to the community, partners, and clients. This loss additionally creates concerns in developing sustainability with strategic and succession planning.

Another ongoing challenge is an aging facility. The main HSA Scenic campus experienced a complete blackout for 24 hours of phone and computers due to an electrical failure in August 2015. County and HSA administration are in the process of developing a facility plan to relocate critical patient services in the next year, and remaining services within two years.

Core Functions

As stated earlier, the practice of Public Health is guided by the 10 Essential Services, broadly grouped into the three core functions of *Assessment*, *Policy Development*, and *Assurance.* National Public Health Accreditation is built on 12 Domains, 10 of which strategically align with the essential services (see Table 1). The additional two domains are Administration/Management and Governance. As HSA/PH continues on the path toward accreditation, it has become apparent that new custom and practice will rely on strategic assessment, evaluation, and integration based on those 10 Essential Services. This is currently being infused into the existing public health business model.

Last year's Board Report focused on *Communicable Disease Prevention and Control* – falling into the core area of 'Assessment'. This report focuses on the importance of the three prerequisites of public health accreditation – the 2013 Community Health Assessment (CHA), 2010-2020 Community Health Improvement Plan (locally known as the *Framework for a Thriving Stanislaus)*, and the 2015 PH Strategic Plan. In brief, the CHA relies on data to illustrate the state of the community. The Framework for a Thriving Stanislaus (FTS) is the second phase following completion of the CHA and uses the data collected from that assessment to identify community-wide objectives. The FTS is the community-facing strategic plan for health and is integrated into the HSA/PH Division-specific strategic plan. The strategic plan defines terms and sets expectations for the process. It allows HSA/PH to establish strategic priorities and develop implementation plans.

Table 1: The 3 Core Functions and 10 Essential Public Health Services

Core Function	*Essential Service*
Assessment	1. Monitor health status to identify and solve community health problems.
	2. Diagnose and investigate health problems and health hazards in the community.
Policy Development	3. Inform, educate, and empower people about health issues.
	4. Mobilize community partnerships and action to identify and solve health problems.
	5. Develop policies and plans that support individual and community health efforts.
Assurance	6. Enforce laws and regulations that protect health and ensure safety.
	7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
	8. Assure competent public and personal health care workforce.
	9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
	10. Research for new insights and innovative solutions to health problems.

Core Function: Assessment

Essential Services

1. ***Monitor health status to identify and solve community health problems.***
2. ***Diagnose and investigate health problems and health hazards in the community.***

Community Health Assessment

The Community Health Assessment (CHA), *Essential Service 1,* provides baseline data which makes up the overall portrait of health throughout Stanislaus County. The use of data includes detecting areas for health improvement, determining factors that contribute to health issues, and identifying assets and resources that can be utilized to address the improvement of population health. The CHA provides greater definition to the role of data and its relation to epidemiology and surveillance (the foundation for public health), the general public, partners, and a host of others invested in community improvement – serving as the building blocks for the functional framework of public health and the community (see Figure 2).

The process of developing the CHA takes place through a national initiative referred to as Mobilizing for Action through Planning and Partnerships (MAPP), developed by NACCHO. MAPP is a community-based strategic planning process which recognizes that public health (specifically HSA/PH) serves as the primary convener of a process that must extend beyond the local governing agency. As such, the CHA includes broad participation by various stakeholders.

The 2008 CHA led to an initial 'MAPP Stakeholder' Workshop in 2009, attended by over 100 people representing more than 50 agencies, during which attendees identified four focus areas for community health improvement, now referred to as the *broad determinants of health*. They are:

1) Education
2) Basic Needs (food, housing, employment, income, child care)
3) The Built Environment (transportation, safety, walkability, etc.)
4) Access to Health Information and Health Care

Figure 2: The Mobilizing for Action through Planning and Partnerships (MAPP) Process

Disease Monitoring, Diagnosis, and Investigation

One of public health's mandates is disease monitoring and surveillance indicated in *Essential Services 1 & 2.* The prevention and control of communicable diseases relies on identification, treatment, and reporting of diseases and conditions throughout California. These reportable conditions are listed in the California Health and Safety Code, Title 17, Section 2500.

Even more important than reporting is how to deliver appropriate public health measures with medical, non-medical, and general communities. In recent history, there has not been an example of the need for disease control measures more than Ebola. The need for coordinated and effective communication on appropriate protocol was most pronounced during the crisis that resulted in the loss of more than 11,000 people, primarily in West Africa. In January 2015, public health at all levels – international, national, state, and local – entered the fourth month of the international Ebola crisis. The CDC, CDPH, and multiple other agencies responded with heightened response measures due to the ease of transmission and mortality associated with the disease. Staff from the HSA Communicable Disease Section [Community Assessment Planning and Evaluation - CAPE, PH Laboratory, and Emergency Preparedness (EP)] worked together with partners in Emergency Medical Services, hospitals, and clinics to stay informed and share new CDC/State guidelines. From those local efforts, a response plan was completed. On January 5, 2016, the following statement was issued to local public health officials:

> "As you know by now, on December 29, 2015, the World Health Organization declared the end of Ebola virus transmission in the Republic of Guinea. In the declaration, WHO stated that "the end of Ebola transmission in Guinea marks an important milestone in the Ebola outbreak in West Africa." All three West African nations impacted by the outbreak now have Ebola Virus Disease (EVD) under control after a combined 28,601cases and the deaths of 11,300 people. This milestone is indeed an excellent New Year gift to Liberia, Sierra Leone, Guinea, and the international public health community at large."
>
> -Gilberto F. Chavez, MD, MPH
> Deputy Director, Center for Infectious Diseases/California Department of Public Health

Statewide, 1,295 travelers from West Africa were monitored by local health departments; Stanislaus County was fortunate not to have any such travelers to monitor. This can be largely attributed to our local partners in international ministries taking appropriate actions to safeguard their staff and volunteers.

Zika Virus

In May 2015, the Pan American Health Organization (PAHO) issued an alert regarding the first confirmed Zika virus infection in Brazil. Since that time, the HSA/PH Communicable Disease Surveillance programs have been monitoring the spread of the virus and have been working with our partners at the federal and state level through participation in conference calls and local dissemination of information to clinical and hospital providers, as well as the general public. For many years, HSA/PH has maintained strong relationships with the two local vector abatement districts: East Side and Turlock Mosquito Abatement Districts. This partnership has expanded due to the emerging threat of Zika virus and other mosquito-borne illnesses. West Nile Virus is present in our county and is the focus of our prevention efforts with the abatement districts.

Table 2: Assessment Outcomes FY 2014/15

Essential Service	*Definition*
1. ASSESS	Conduct and disseminate assessments focused on population health status and public health issues facing the community.
Outcomes	• The Community Health Assessment *Community Report* was shared with over 900 partners through meetings and distribution. • Interagency Family Violence Death Review Team (DRT) examined 25 cases of child death, and 50 cases of adult death due to child and elder abuse and neglect, intimate partner violence, and suicide[1]. • Implemented Persimmony electronic case management record to collect data for case management and maternal child adolescent health outcomes. • Office of Vital Records recorded: o 10,044 Births Registered o 4,632 Deaths Registered
2. INVESTIGATE	Diagnose, investigate, and mitigate health problems to protect the community.
Outcomes	• 13 disease outbreaks investigated to protect the community and control communicable disease. • 8,160 diseases reported to PH, under Title 17 § 2500 of the CA H&SC[2]. • Held weekly communicable disease surveillance meetings with internal stakeholders. • 9,433 PH laboratory tests conducted to support outbreak investigations and control of diseases in 2015 including: o 901 microbiologic laboratory tests (e.g. for rabies, parasitology, food-borne illnesses, and tuberculosis) to aid in determination of diagnosis; o 1,690 immunology serology tests (e.g. blood tests for syphilis, tuberculosis, HIV ,and West Nile Virus); o 1,580 toxicology tests (e.g. lead screening); o 4,639 molecular tests (e.g. chlamydia, gonorrhea, and influenza); and o 623 environmental tests (e.g. dairy and recreational water samples). • Improved ability to exchange public health information with providers by implementing the Laboratory Information Management system project, 75% completed.

[1] The Death Review Team operates under California Penal Codes 11163.3-11163.5, 11166.7-11166.9 and 11174.4-11174.9

[2] Mandate PH function, Title 17, CCR Health and Safety Code § 2500

Core Function: Policy Development

Essential Services

3. ***Inform, educate, and empower people about health issues.***
4. ***Mobilize community partnerships and action to identify and solve health problems.***
5. ***Develop policies and plans that support individual and community health efforts.***

Community Health Improvement Plan

The Community Health Improvement Plan (CHIP), locally known as the *Framework for a Thriving Stanislaus (Framework),* is a broad community initiative that lays out intended community results with targets to achieve alignment with Healthy People 2020, a national effort best characterized by the slogan:

> *"Health begins where people live, learn, work and play."*
> -Robert Wood Johnson Foundation adopted by the Centers for Disease Control and Prevention

The *Framework for a Thriving Stanislaus (FTS)* was developed largely based on the findings of the 2008 CHA and serves as the second phase of plan completion for the accreditation application. The development and implementation of the *Framework* requires HSA/PH to serve as the facilitator between the community and other government entities. This partnership intentionally involves a variety of different partners who lead the implementation of the objectives developed. In 2010, the CHIP became locally known as the *Framework for a Thriving Stanislaus* to better reflect the incorporation of non-traditional partners working towards a healthy, prosperous, and thriving community. As mentioned earlier in the report, the *FTS* focuses on four broad determinants of health: Education, Basic Needs/Economy, Access to Health Information and Healthcare, and the Built Environment, consistent with the data identified throughout the CHA. The *Framework* has become the community-facing proposal for health and serves as the building block for the internal HSA/PH Division-specific strategic plan.

HSA/PH Strategic Plan

The final prerequisite for the public health accreditation application is a public health-specific strategic plan. While HSA has a three-year agency strategic plan, HSA/PH was required to have a plan speaking specifically to public health goals and activities. To achieve this, in September 2015 a Strategic Planning Committee (SPC) was assembled and included 15 members from HSA and key partner organizations (Chief Executive Office, Center for Human Services, West Modesto Collaborative, etc.). The Managing Director, Mary Ann Lee, also participated in the process. The SPC met for four (4) six-hour sessions, during which participants reviewed data on the health status and needs of the county; community and agency plans for action; budgets, employee, and customer satisfaction surveys; SWOT analyses (Strengths Weaknesses Opportunities Threats); and other metrics

of HSA/PH functions. The SPC selected six priority areas around which to structure the strategic plan. Three of the six priorities focus on overall agency functions ("internal" priority areas), while the remaining three strategic priorities focus on population health outcomes ("external" priority areas). The revised strategic priorities, goals, and objectives were presented to the SPC at the fourth and final strategic planning session in October 2015, where they were discussed and adopted. The six priorities selected were:

Internal Priority Areas

1. Effective Communication
2. Workforce Development
3. Culture of Quality Improvement

External Priority Areas

4. Narrowing the Gap
5. A Healthy Foundation
6. Wellness Across the Lifespan

The plan was completed in November, and in December 2015 received approval from the Board of Supervisors. HSA/PH moved forward with submitting an accreditation application in December. The strategic plan serves as a communication tool in making decisions and allocating resources to improve population health and organizational effectiveness to better serve this community. The PH Division strategic plan aligns with the HSA Strategic Plan.

2015 HSA/PH Division Strategic Planning Committee (SPC) from L to R: Gregory Shuping (HSA/WIC); Pete Duenas (County Executive Office); Anuj Bhatia (HSA); Rebecca Nanyonjo-Kemp (HSA); Mary Ann Lee (HSA); Cynthia Haynes (HSA); Dawn Hinkle (HSA/CCS); Phoebe Leung (Facilitator); Cindy Duenas (Center for Human Services); John Walker, MD (HSA); Kyle Fliflet (HSA/NEOP); Andria Jimenez (HSA/CAPE); Jim Ferrera (HSA/EP); Sharon Hutchins (HSA/CAPE); Debbie Jo Trinidade (HSA). Not pictured: Cle Moore-Bell (West Modesto/King Kennedy Collaborative).

Table 3: Policy Development Outcomes FY 2014/15

Essential Service	*Definition*
3. INFORM AND EDUCATE	Inform, educate, and empower people about health issues.
Outcomes	• 3,750 Nutrition Education classes taught to WIC clients. • 240 HBO classes taught at Family Resource Centers throughout the county. • 48 Media Inquiries addressed by HSA staff • 10 Medical Provider updates sent out through fax • 14 Lead poisoning prevention classes taught to resident program, child care providers and parents/care givers • 442 parents attended KBS classes, child passenger safety education. • 1,668 students educated on teen pregnancy prevention and healthy relationships at 12 locations (6 schools, juvenile hall, and other locations). • 340 children and 263 parents were educated on dental disease prevention at 23 sites; 453 children received fluoride varnish applications. • 1,197 classes taught in the community for NEOP.
4. COMMUNITY ENGAGEMENT	Engage with the community to identify and address health problems.
Outcomes	• The NEOP program trained 207 early childcare providers to engage students in nutrition education, specifically focusing on 'Harvest of the Month'. • MCAH developed the 5-Year Action Plan with 30 community partners. There were ten meetings with partners over the course of the fiscal year. • Partnership with the Stanislaus County Asthma Coalition continued to plan annual provider education conference. • Participated with the Child Abuse Prevention Council to implement the Strengthening Families Framework in Stanislaus County. • The Emergency Preparedness Medical Reserve Corps recruited 44 licensed and 24 non-licensed volunteers.
5. POLICIES & PLANS	Develop public health policies and plans.
Outcomes	• The Executive Committee of the CHIP (aka Framework for a Thriving Stanislaus) met 4 times, with 3 subcommittees meeting 18 times for the purposes of developing collectively established objectives and ensuring alignment with the county-wide Focus on Prevention initiative. • HSA/PH developed the 2015-18 strategic plan, with 6 priority areas. • Maintained an All Hazards Emergency Operations Plan and participated on the interagency revision team. • Intra-agency team selected a document management system "Policy Tech" to place all policies and procedures into a standard format for universal access, timely review, and training. • CCS/CHDP program managers participated in state calls, regional meetings, and work groups to discuss program redesign with Medi-Cal Managed Care.

Core Function: Assurance

Essential Services

6. ***Enforce laws and regulations that protect health and ensure safety.***
7. ***Link people to needed personal health services and assure the provision of health care when otherwise unavailable.***
8. ***Assure competent public and personal health care workforce.***
9. ***Evaluate effectiveness, accessibility, and quality of personal and population-based health services.***
10. ***Research for new insights and innovative solutions to health problems.***

Enforcing Laws and Regulation to Ensure Health and Safety

The core public health function of 'Assurance' involves conducting a variety of activities that include the enforcement of policies and regulations. This function is usually implemented by environmental health, which in the case of Stanislaus County, is separate from the HSA Department. Historically, public health has also played the role of a safety net for providing care in the community. However, with the passage of the Affordable Care Act, primary care services have largely and distinctly transitioned into community clinics.

Addressing Gaps in Accessibility

Public Health still provides critical safety net services: immunizations for children without access to primary care, sexually transmitted disease screening clinic, and management of active tuberculosis. In certain situations where clients cannot physically come to locations that provide services, HSA/PH will bring those resources to them. Through programmatic operations somewhat unique to Public Health, nurses and community health workers serve vulnerable families in their homes, to improve birth outcomes and prevent abuse with evidenced-based practices.

Assure a Competent Workforce

In addition to the need for developing and retaining internal resources, HSA/PH also partners with academic and professional institutions for internship placement. The CDC Public Health Associate Program is a program which provides paid internships for recent college graduates to gain practical experience working in a local health department. In 2015, HSA/PH was fortunate to be matched with two interns. Their skillsets have been utilized in a variety of tasks including the coordination of the exercises and after action reporting in Emergency Preparedness, assessment of staff knowledge and attitudes on social issues in public health, providing professional presentations, developing process flow diagrams, and assisting in the assessment of current operations.

Evaluate Effectiveness and Quality of Health Services & Innovative Solutions

HSA is a large organization with multiple divisions and programs, each generating policies and procedures without standardization or universal access to all programs. In 2015, a

workgroup was formed to evaluate several bids for a web-based document management system; Policy Tech was selected mid-year. Members from HSA leadership began training and installation in November 2015. Implementation of Policy Tech will take about two years, touching each employee in HSA.

To facilitate meeting accreditation standards and to seek best practices concerning performance management, PH applied and was awarded an Accreditation Supportive Initiative (ASI) $15,000 grant from NACCHO.

Table 4: Assurance Outcomes FY 2014/15

Essential Service	*Definition*
6. PH LAWS	Enforce public health laws.
Outcomes	• CD staff worked with medical providers to ensure 4,450 reports of mandated diseases to the state.[1] • Applied and received Office of Traffic Safety grant to improve compliance with child passenger safety laws. • Child Health and Disability Program monitored compliance with well child exam regulations for 40 provider sites. • Educated 93 new staff on mandated reporting responsibilities surrounding child and elder abuse, neglect and intimate partner violence.
7. ACCESS TO CARE	Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
Outcomes	• PH Clinic provided the following services: o 8,407 Immunizations to clients, age breakdown see Appendix A. o 1,020 client visits for STD clinic.[1] • PH Tuberculosis Clinic provided the following services:[1] o 2,396 TB Skin Tests "Only". o 2,229 TB visits for medication and assessments. o 9 Active TB clients managed, with contact investigation. • 96 clients received HIV/AIDS case management. o 496 HIV tests administered, in community setting. • Case Management through PHN/CHW Field Visits. o 7,889 home visits (HBO, NFP, HRMCH, Cal Learn/AFLP), Appendix A • 8 Children with high blood levels of lead case managed.[2] o 7 children with abnormal blood lead levels monitored • 3,157 children case managed in CCS, at any point in time. o 2,245 children referred to CCS and evaluated for services. o 7,399 Therapy (OT/PT) visits at Sonoma Medical Therapy Program. • 18,913 clients reached for WIC Nutrition Services. o 19,330 WIC vouchers distributed each month
8. WORKFORCE	Maintain a competent public health workforce.
Outcomes	• Through the Strategic Planning Process, identified Workforce Development as a strategic priority area with 3 goals to accomplish over the next three years. • 23 Drills/Exercises/Trainings provided through Emergency Preparedness. • Served as Registered Nurse Continuing Education, 60 certificates given out for 3 educational events. • Hosted two trainees through the CDC Public Health Associate Program. • Acted as a training site for Modesto JC and CSU Stanislaus Nursing students.

Table 4: Assurance Outcomes FY 2014/15

9. QUALITY IMPROVEMENT	Evaluate and continuously improve health department processes, programs, and interventions.
Outcomes	• Through the Strategic Planning Process, identified Performance Management and Quality Improvement as a strategic priority area with 3 goals. • Applied for and awarded a $15,000 Accreditation Supportive Initiative (ASI) grant, from NACCHO. • Performed chart review of congenital syphilis cases, for missed opportunities and process improvement between PH, HSA clinics, and hospitals. • Comprehensive Perinatal Services Program made 9 QI technical assistance visits.
10. SYSTEM MANAGEMENT	Contribute to and apply the evidence base of public health.
Outcomes	• Received Board of Supervisors Letter of Support to Apply for PHAB December 2015. • Submitted application for Public Health Accreditation, December 2015.

[1] Mandate PH function, Title 17, CCR Health and Safety Code § 2500

[2] CDPH Recommended Program CCR Health and Safety Code § 105275 - 105310

Conclusions/Looking Ahead

Much work is underway in relation to public health accreditation and the strategic plan. Numerous committees, such as Effective Communication, Workforce Development, and Performance Management System/Quality Improvement (PMS/QI) have begun meeting. This has resulted in the development of formal protocols and policies that will guide HSA/PH to address both specific PHAB guidance as well as objectives within the Strategic Plan. These efforts reflect an increasingly progressive role of the HSA/PH where the 10 Essential PH Services and the broad determinants of health better define its role as the primary population health strategist for Stanislaus County.

Subsequent HSA/PH annual reports will follow the format of the 10 Essential Services, with outcomes and highlights in each area. The most significant data will again be available in the annual summary of key metrics, as an appendix to the report.

All of us in HSA/PH hope you have enjoyed reading this annual report, and celebrate with us the accomplishments in moving towards our vision of "*Healthy People in a Healthy Stanislaus!*"

Appendices – 2015 Stanislaus County PH Annual Report

A. Public Health Key Metrics 2014-2015
B. 2016 California Department of Public Health County Profile
C. Public Health Organizational Chart
D. Community Health Assessment Brief
E. Community Health Improvement Plan Brief – *Framework For a Thriving Stanislaus*
F. HSA/PH Division Strategic Plan Brief
G. Glossary of Acronyms

Appendix A: Public Health Key Metrics 2014-2015

Stanislaus County Public Health Key Metrics Summary 2014-2015			
Revised 5/5/2016	**2014/15**	**2015/16**	**2016/17**
Public Health Clinics			
Clients, Immunization age 0-18	4,358		
Clients, Immunization age 19+	4,049		
Clients, Flu Vaccine, community setting (included above)	1,542		
STD Clinic, clients seen	1,020		
TB Skin Test Only	2,396		
TB III Medication Visits (DOT)	1,178		
TB Chest Clinic MD	47		
TB History, med starts, refills (Class II)	1,051		
TB (Class III) Pulmonary/Extra Pulmonary	9		
Communicable Disease Program			
# of Title 17 conditions reported in CalREDIE	4,450		
# of Title 17 conditions investigated in CalREDIE	8,160		
# of Title 17 outbreaks investigated	13		
Chlamydia cases reported	2,798		
Gonorrhea cases reported	752		
Syphilis total cases (confirmed/probable)	107 confirm / 119 p		
Syphilis cases in women 12-44 yrs. (child bearing)	31 confirm / 52 p		
Congenital Syphilis cases reported (probable) [1]	4		
Clients in HIV/AIDS case management	96		
# of HIV Tests (non-STD clinic) community/anonymous	496		
Vital Records			
Births Registered	10,044		
Deaths Registered	4,632		
Community Health Services			
Healthy Birth Outcomes (HBO) home visits	2,029		
Nurse Family Partnership (NFP) home visits	1,447		
High Risk Maternal Child Health home visits	1,785		
Cal Learn/Adolescent Family Life Program home visits	2,628		
HBO Classes taught by staff	240		
Children with high blood lead levels case managed/monitored	8/7		
California Children's Services/Medical Therapy			
New client referrals	2,245		
Straight CCS case load managed	172 (5.44%)		
MC/TLICP CCS case load managed	351 (11.13%)		
Medi-Cal case load managed	2,634 (83.44%)		
Total Average Case Load	3,157		
Medical Therapy (OT/PT/MTC) visits	7,399		
Nutrition Program			
Caseload reached	18,913		
Average WIC vouchers distributed/month	19,330		
WIC Classes taught in FY	3,750		
Nutrition Education Obesity Prevention classes	1,197		
Emergency Preparedness			
Number of Drills/ Exercise/Trainings	23		
New Medical Reserve Corps (licensed/non-licensed) volunteers	44/24		

Appendix B: 2016 CDPH County Health Profile

STANISLAUS COUNTY'S HEALTH STATUS PROFILE FOR 2016

MORTALITY

RANK ORDER	HEALTH STATUS INDICATOR	2012-2014 DEATHS (AVERAGE)	CRUDE DEATH RATE	AGE-ADJUSTED DEATH RATE	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	NATIONAL OBJECTIVE	AGE-ADJUSTED DEATH RATE CALIFORNIA CURRENT	AGE-ADJUSTED DEATH RATE COUNTY PREVIOUS
49	ALL CAUSES	3,889.3	737.7	786.5	761.5	811.5	a	619.6	769.4
53	ALL CANCERS	859.3	163.0	172.3	160.7	184.0	161.4	146.5	161.8
57	COLORECTAL CANCER	87.7	16.6	17.7	14.2	21.8	14.5	13.3	16.3
44	LUNG CANCER	195.3	37.0	39.5	33.9	45.1	45.5	31.7	41.9
48	FEMALE BREAST CANCER	60.3	22.7	22.1	16.9	28.5	20.7	20.3	19.8
43	PROSTATE CANCER	43.7	16.7	21.9	15.9	29.5	21.8	19.3	19.0
40	DIABETES	108.0	20.5	21.6	17.5	25.7	b	20.4	22.4
54	ALZHEIMER'S DISEASE	192.7	36.5	40.8	35.0	46.5	a	30.1	38.1
57	CORONARY HEART DISEASE	717.3	136.1	146.3	135.5	157.1	103.4	96.6	154.8
53	CEREBROVASCULAR DISEASE (STROKE)	214.7	40.7	44.7	38.6	50.7	34.8	34.4	44.2
46	INFLUENZA/PNEUMONIA	87.7	16.6	17.7	14.2	21.9	a	15.3	19.1
44	CHRONIC LOWER RESPIRATORY DISEASE	229.0	43.4	47.0	40.9	53.2	a	33.7	48.3
38	CHRONIC LIVER DISEASE AND CIRRHOSIS	78.3	14.9	14.9	11.8	18.6	8.2	11.7	13.2
29	ACCIDENTS (UNINTENTIONAL INJURIES)	191.3	36.3	37.0	31.7	42.3	36.4	28.2	38.1
34	MOTOR VEHICLE TRAFFIC CRASHES	66.7	12.6	12.7	9.9	16.2	12.4	7.9	11.5
21	SUICIDE	56.0	10.6	10.8	8.2	14.1	10.2	10.2	11.4
44	HOMICIDE	34.7	6.6	6.5	4.5	9.0	5.5	5.0	6.4
29	FIREARM-RELATED DEATHS	52.7	10.0	10.0	7.4	13.0	9.3	7.6	9.5
33	DRUG-INDUCED DEATHS	77.3	14.7	14.7	11.6	18.4	11.3	11.3	17.0

MORBIDITY

RANK ORDER	HEALTH STATUS INDICATOR	2012-2014 CASES (AVERAGE)	CRUDE CASE RATE	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	NATIONAL OBJECTIVE	CRUDE CASE RATE CALIFORNIA CURRENT	CRUDE CASE RATE COUNTY PREVIOUS
35	AIDS INCIDENCE (AGE 13 AND OVER)	15.3	3.6 *	2.0	5.9	a	7.3	4.6 *
41	CHLAMYDIA INCIDENCE	2,064.3	391.5	374.7	408.4	c	447.0	354.1
46	GONORRHEA INCIDENCE FEMALE AGE 15-44	228.3	208.6	181.5	235.6	251.9	172.1	65.6
50	GONORRHEA INCIDENCE MALE AGE 15-44	262.7	233.9	205.6	262.1	194.8	255.6	62.7
22	TUBERCULOSIS INCIDENCE	10.0	1.9 *	0.9	3.5	1.0	5.7	2.9 *

INFANT MORTALITY

RANK ORDER	HEALTH STATUS INDICATOR	2011-2013 DEATHS (AVERAGE)	BIRTH COHORT (BC) INFANT DEATH RATE	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	NATIONAL OBJECTIVE	BC INFANT DEATH RATE CALIFORNIA CURRENT	BC INFANT DEATH RATE COUNTY PREVIOUS
50	INFANT MORTALITY: ALL RACES	49.0	6.4	4.7	8.5	6.0	4.7	5.5
54	INFANT MORTALITY: ASIAN/PI	3.7	8.3 *	2.1	22.0	6.0	3.6	5.2 *
54	INFANT MORTALITY: BLACK	3.3	20.9 *	4.8	58.0	6.0	9.7	14.5 *
49	INFANT MORTALITY: HISPANIC	25.3	6.2	4.0	9.1	6.0	4.6	6.5
44	INFANT MORTALITY: WHITE	15.3	5.9 *	3.3	9.7	6.0	3.9	3.5 *

NATALITY

RANK ORDER	HEALTH STATUS INDICATOR	2012-2014 BIRTHS (AVERAGE)	PERCENT	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	NATIONAL OBJECTIVE	PERCENTAGE CALIFORNIA CURRENT	PERCENTAGE COUNTY PREVIOUS
27	LOW BIRTHWEIGHT INFANTS	475.3	6.3	5.7	6.9	7.8	6.7	6.2
27	FIRST TRIMESTER PRENATAL CARE	5,817.3	78.7	76.7	80.7	77.9	83.5	77.7
46	ADEQUATE/ADEQUATE PLUS PRENATAL CARE	4,886.7	68.7	66.8	70.7	77.6	78.6	71.0

RANK ORDER	HEALTH STATUS INDICATOR	2012-2014 BIRTHS (AVERAGE)	AGE-SPECIFIC BIRTH RATE	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	NATIONAL OBJECTIVE	AGE-SPECIFIC BIRTH RATE CALIFORNIA CURRENT	AGE-SPECIFIC BIRTH RATE COUNTY PREVIOUS
41	BIRTHS TO MOTHERS AGED 15-19	612.0	30.2	27.8	32.6	a	23.4	38.5

BREASTFEEDING

RANK ORDER	HEALTH STATUS INDICATOR	2012-2014 BREASTFED (AVERAGE)	PERCENT	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	NATIONAL OBJECTIVE	PERCENTAGE CALIFORNIA CURRENT	PERCENTAGE COUNTY PREVIOUS
54	BREASTFEEDING INITIATION	5,870.7	87.9	85.6	90.1	81.9	92.9	d

CENSUS

RANK ORDER	HEALTH STATUS INDICATOR	2013 NUMBER	PERCENT	95% CONFIDENCE LIMITS LOWER	95% CONFIDENCE LIMITS UPPER	NATIONAL OBJECTIVE	PERCENTAGE CALIFORNIA CURRENT	PERCENTAGE COUNTY PREVIOUS
47	PERSONS UNDER 18 IN POVERTY	43,722	30.4	30.2	30.7	a	23.3	27.1

Appendix B: 2016 CDPH County Health Profile

STANISLAUS COUNTY

County Health Status Profiles Data Analysis for 2016

Rate Type	Table Number	Table Description	Profiles 2016 Rate	+ Comparison Period Rate	Amount of Change	* Percentage Change	Healthy People Objective	Compared to CA
AAR	1	ALL CAUSES	786.5	769.4	17.1	2.2	NONE	wrs
AAR	2	ALL CANCERS	172.3	161.8	10.5	6.5	not met	wrs
AAR	3	COLORECTAL CANCER	17.7	16.3	1.4	8.6	not met	wrs
AAR	4	LUNG CANCER	39.5	41.9	-2.4	-5.7	MET	wrs
AAR	5	FEMALE BREAST CANCER	22.1	19.8	2.3	11.6	not met	wrs
AAR	6	PROSTATE CANCER	21.9	19.0	2.9	15.3	not met	wrs
AAR	7	DIABETES	21.6	22.4	-0.8	-3.4	NONE	wrs
AAR	8	ALZHEIMER'S DISEASE	40.8	38.1	2.7	7.0	NONE	wrs
AAR	9	CORONARY HEART DISEASE	146.3	154.8	-8.5	-5.5	not met	wrs
AAR	10	CEREBROVASCULAR DISEASE (STROKE)	44.7	44.2	0.5	1.0	not met	wrs
AAR	11	INFLUENZA/PNEUMONIA	17.7	19.1	-1.3	-7.0	NONE	wrs
AAR	12	CHRONIC LOWER RESPIRATORY DISEASE	47.0	48.3	-1.3	-2.7	NONE	wrs
AAR	13	CHRONIC LIVER DISEASE AND CIRRHOSIS	14.9	13.2	1.7	12.6	not met	wrs
AAR	14	ACCIDENTS (UNINTENTIONAL INJURIES)	37.0	38.1	-1.2	-3.1	not met	wrs
AAR	15	MOTOR VEHICLE TRAFFIC CRASHES	12.7	11.5	1.3	11.1	not met	wrs
AAR	16	SUICIDE	10.8	11.4	-0.6	-4.9	not met	wrs
AAR	17	HOMICIDE	6.5	6.4	0.0	0.6	not met	wrs
AAR	18	FIREARM-RELATED DEATHS	10.0	9.5	0.5	4.9	not met	wrs
AAR	19	DRUG-INDUCED DEATHS	14.7	17.0	-2.3	-13.6	not met	wrs
CCR	21	CHLAMYDIA INCIDENCE	391.5	354.1	37.5	10.6	NONE	BTR
CCR	22F	GONORRHEA INCIDENCE FEMALES AGED 15-44	208.6	65.6	143.0	217.8	MET	wrs
CCR	22M	GONORRHEA INCIDENCE MALES AGED 15-44	233.9	62.7	171.2	273.1	not met	BTR
IMR	24A	INFANT MORTALITY: ALL RACES	6.4	5.5	0.9	17.2	not met	wrs
IMR	24D	INFANT MORTALITY: HISPANIC	6.2	6.5	-0.3	-5.0	not met	wrs
PER	25	LOW BIRTHWEIGHT INFANTS	6.3	6.2	0.1	2.2	MET	BTR
ASB	26	BIRTHS TO MOTHERS AGED 15-19	30.2	38.5	-8.3	-21.6	NONE	wrs
PER	27A	FIRST TRIMESTER PRENATAL CARE	78.7	77.7	1.0	1.3	MET	wrs
PER	27B	ADEQUATE/ADEQUATE PLUS PRENATAL CARE	68.7	71.0	-2.3	-3.2	not met	wrs
PER	28	BREASTFEEDING INITIATION	87.9	a			MET	wrs
A comparison could not be made for the following tables due to unreliable rates in either or both years.								
CCR	20	AIDS INCIDENCE (AGE 13 AND OVER)						
CCR	23	TUBERCULOSIS INCIDENCE						
IMR	24B	INFANT MORTALITY: ASIAN/PI						
IMR	24C	INFANT MORTALITY: BLACK						
IMR	24E	INFANT MORTALITY: WHITE						

Column Headings

Rate Type
AAR = Age-adjusted rate
CCR = Crude case rate **IMR** = Infant mortality rate **PER** = Percentage
ASB = Age-specific birth rate
For more information about rates, please see County Health Status Profiles 2016, Technical Notes.

+ a Commensurable Comparison Period Rate is not available
* Rate change percentages were calculated before rates were rounded. These may differ slightly when rate change percentages are calculated from rates rounded to the nearest one-tenth.

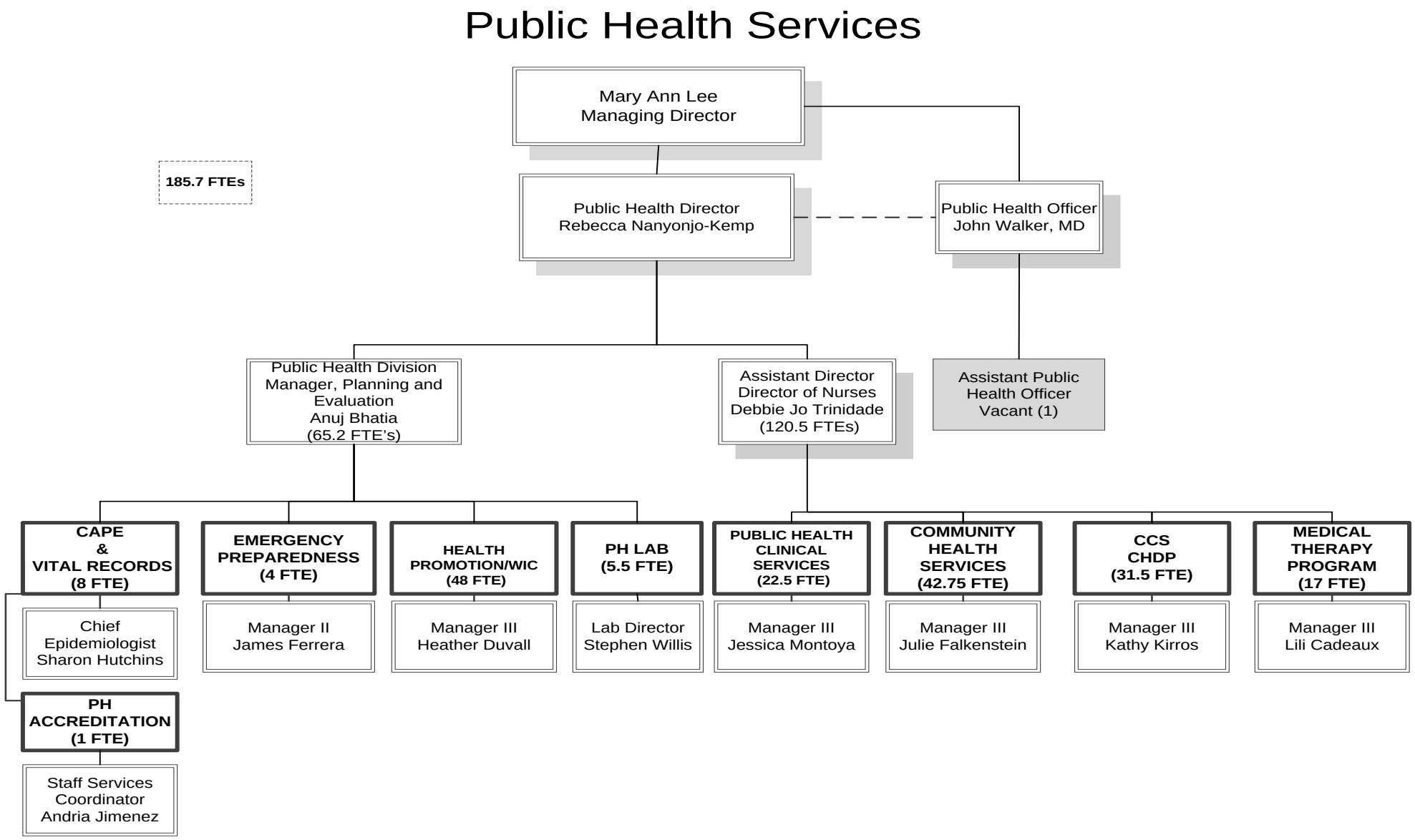
Profiles 2016 Rates are generally based on 2012-2014 data. The one exception is Infant Mortality Rates (2011-2013).
Comparison Period Rates are generally based on 2009-2011 data. The one exception is Infant Mortality Rates (2008-2010).

Amount of Change & Percentage Change
For **Tables 1** to **26**, negative numbers indicate improvement because smaller numbers indicate better results.
For **Tables 27A** and **27B**, positive numbers indicate improvement because for these tables larger numbers indicate better results.

The target rates established for **Healthy People 2020 National Objectives** were applied.

Compared to CA category indicates if the county's performance was worse (**wrs**), better (**BTR**) or equal to (**=**) the State of California.

Appendix C: Public Health Organizational Chart



Health Benefits of Community Health Assessment

Standards for national public health department accreditation require the conduct of a Community Health Assessment (CHA) every three to five years. HSA/Public Health conducts its CHAs with partners every five years. The *2013 Stanislaus County Community Health Assessment* (2013 CHA) was a multi-agency assessment of multiple indicators of community and personal well-being in Stanislaus County led by the Health Services Agency (HSA). It consisted of a review and discussion of dozens of secondary data sources on the demographic profile of the County, its economic and employment status, crime and public safety, education, environmental, and behavioral risk and protective factors, incidence, prevalence, morbidity and mortality of important perinatal, chronic, communicable, behavioral and mental conditions as well as life expectancy.

Community health assessments are designed to enhance the health of our community in three ways:

1) The CHA serves to draw attention to major community issues that can then be targeted for improvement and helps provide a "report card" to monitor improvements. The 2008 CHA was the basis of the *Framework for a Thriving Stanislaus* (FTS), the local community health improvement plan. Likewise, the 2013 CHA is being used to modify the FTS, suggesting new priorities revealed by the data and identifying areas where new strategies or activities are needed to make progress toward existing goals. The brief 2013 *Community Report* published in August, 2014, served to draw community attention to needs within the area of education and highlighted the need to expand literacy and mentoring programs; this helped spark interest and participation in *Stanislaus Reads* and *Destination Graduation*. At the April 28, 2016 *Connecting for Good* event, in which community leaders and members gathered to learn about effective Collective Impact strategies, CHA data was heavily used to justify the focus areas chosen.

2) The CHA is useful for program planning and evaluation. When the 2013 *Community Report Brief* was published in August, 2014, the highlighted increasing trend in suicides served in providing information to BHRS, community and political leaders in creating new efforts to reduce this emerging problem.

3) The CHA serves as a rich repository of information on community needs and assets, allowing development of competitive applications for grant funding to address those needs. Many non-profit agencies in the County that do not have internal capacity for needs assessment rely on the CHA for this purpose. HSA personnel also use the CHA as a source of trusted data to include in their program proposals. Grants received by external agencies that used CHA data in their narratives include Safe Routes to School. Grants received by HSA/Public Health programs that incorporated CHA data include Nutrition Education and Obesity Prevention, Teen Pregnancy Prevention, and Tobacco Control and Prevention.

The usefulness of the CHA is highlighted by the fact that the CHA reports were viewed from the HSA webpage 1,869 times in 2015, with 3,278 separate downloads.

2013 Stanislaus County Community Health Assessment

Framework for a Thriving Stanislaus: *Healthy • Educated • Prosperous • Vibrant • Sustainable*

The *Framework for a Thriving Stanislaus* (the local Community Health Improvement Plan) is a 10-year community plan (2011-2020) to improve the broad determinants of health and well-being for Stanislaus County residents. This initiative has a three-part purpose:

1) Focus public attention on four areas ("broad determinants") that underlie a healthy, prosperous, and well-functioning community;
2) Help coordinate efforts in these areas to increase their efficiency and effectiveness; and
3) Inspire new efforts.

The *Framework for a Thriving Stanislaus* (FTS) was developed in response to findings from the *2008 Stanislaus County Community Health Assessment (CHA)* by community members in series of workshops in 2009-2010. The *FTS* has since been refined by task forces of topic area experts and stakeholders, under the guidance of an Executive Team. The *FTS* consists of a set of results toward which the community is working, specific goals, and a set of indicators that are monitored regularly to measure progress.

The four broad determinants were chosen because of the local needs and issues revealed by the *2008 CHA* as well as their fundamental importance to achieving health and well-being.

a. Education: Employers need workers with certain skills. High school graduation rates and test scores are important factors for businesses considering relocation or expansion. In addition, education contributes to health status and life expectancy. People with higher educational attainment usually have better health literacy, adopt healthier lifestyles, report higher quality of life, and live longer.

b. Access to health information and health care: People's health is affected by their access to appropriate health information and health care. Inability to find or get to a personal medical provider often means foregoing care or using a hospital emergency room for routine care, which places a burden on hospital resources and increases wait times for others. A community whose residents are healthy is a community that thrives economically.

c. Basic Needs: Being able to satisfy basic needs (such as food, clothing, housing, and child care) is vital to the survival of individuals, families, and communities. Going without these needs increases the likelihood of stress, chronic illness, lack of trust in the community, and reduced social cohesion, as well as creating an economic burden on other individuals.

d. Built Environment: The "built environment" is a name for the parts of the physical environment built by people (e.g. buildings, roads, utilities, and use of zoning to separate areas for living and working). How a neighborhood is designed, planned, and built affects its economic vitality because it influences residents' access to jobs, educational opportunities, and basic human needs. Built environment decisions also impact residents' health.

Health Benefits of the Strategic Plan

Standards for national public health department accreditation require the development of a departmental strategic plan every three to five years (PHAB Version 1.5, Standard 5.3). The strategic plan should be informed by extensive data, both about the well-being of the community as well as measures of internal function and capacity. HSA/Public Health conducted a division-wide strategic plan in 2015, for the time period 2015-2018. The HSA/Public Health Strategic Plan focuses attention on 6 priority areas—three focused on internal capacity and efficiency (*Effective Communication, A Culture of Quality Improvement,* and *Workforce Development*), and three focused on external relationships and outcomes (*A Healthy Foundation, Wellness Across the Lifespan,* and *Narrowing the Gap*).

The purpose of a strategic plan is to direct the agency's work and its resources to address specific priorities in a coordinated manner. An effective public health strategic plan should help improve the community's health because it focuses the department's efforts on attainable goals and incorporates formal review of progress toward them. The strategic plan includes the following:

a. Systematic Review: The process of reviewing data for each strategic planning cycle allows periodic review and consideration of community health needs and assets as well as internal agency strengths and weaknesses. This process allows the setting of priorities that reflects the internal and external realities in which the department is situated, and that can be realistically attained in the time frame given.

b. Links to CHA and CHIP: PHAB standards require a connection between a department's strategic plan and the community health needs and status it has documented through its CHA, as well as the priorities selected to be addressed through its CHIP. This requirement grounds the strategic plan in the needs, priorities, and capacity of its community and connects the agency's activities with those of the broader community.

c. Inclusion of External Partners: The PHAB requirement to include individuals from outside the agency in its strategic planning process allows for the incorporation of a broader perspective in the setting of agency priorities.

d. Targets and Measures: Incorporation of measurable objectives in the strategic plan ensures that progress is formally and systematically assessed. This allows changes to be made if sufficient progress is not achieved, keeping the focus of the strategic plan on making real advances in departmental capacity and effectiveness as well as actual improvements in the community's health.

Appendix G: Glossary

GLOSSARY OF ACRONYMS	
AFLP	Adolescent Family Life Program
CAPE	Community Assessment Planning & Evaluation
CCR	California Code of Regulations
CCS	California Children's Services
CD	Communicable Diseases
CDC	Centers for Disease Control and Prevention
CDPH	California Department of Public Health
CHA	Community Health Assessment
CHDP	Child Health and Disability Prevention Program
CHIP	Community Health Improvement Plan (Framework for a Thriving Stanislaus)
DRT	Death Review Team
EP	Emergency Preparedness
FTS	Framework for a Thriving Stanislaus
H & SC	Health and Safety Code
HBO	Healthy Birth Outcomes
HRMCH	High Risk Maternal Child Health Program
HSA/PH	Health Services Agency/Public Health Division
KBS	Keep Baby Safe
MAPP	Mobilizing for Action through Planning and Partnerships
MCAH	Maternal, Child and Adolescent Health
MTU	Medical Therapy Unit
NACCHO	National Association of County and City Health Officials
NEOP	Nutrition Education and Obesity Prevention Program
NFP	Nurse Family Partnership
PAHO	Pan American Health Organization
PH	Public Health
PHAB	Public Health Accreditation Board
PIO	Public Information Officer
PMS/QI	Performance Management System/Quality Improvement
SPC	Strategic Planning Committee
WHO	World Health Organization
WIC	Women, Infants, & Children