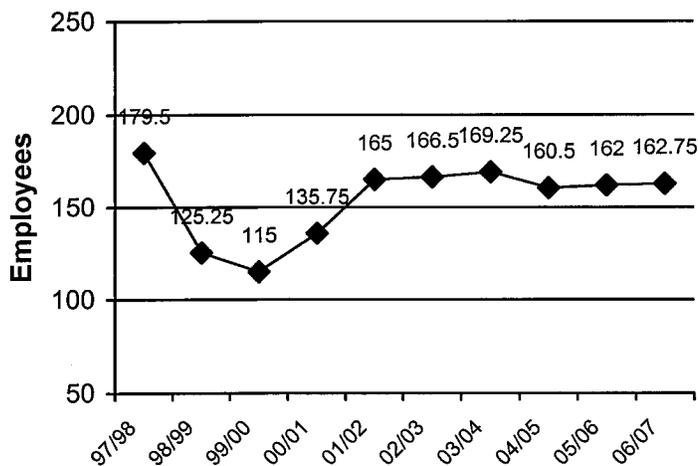


MISSION STATEMENT

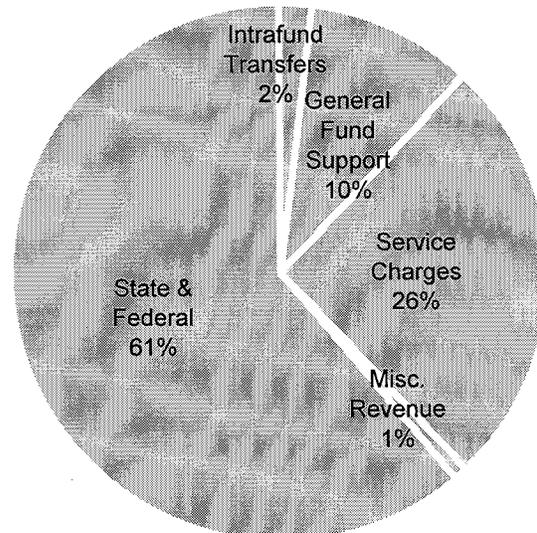
The San Luis Obispo County Public Health Department improves and maintains community health by identifying health issues, preventing disease and injury, influencing policy development and promoting healthy behaviors through leadership, collaborative partnerships, education, direct services, and surveillance.

Financial Summary	2004-05	2005-06	2006-07	2006-07	2006-07
	Actual	Actual	Requested	Recommended	Adopted
Revenues	\$ 17,051,895	\$ 16,797,282	\$ 17,510,268	\$ 17,858,564	\$ 17,886,890
Salary and Benefits	12,498,106	13,247,426	14,264,460	14,476,764	14,478,264
Services and Supplies	5,345,656	5,620,072	5,005,372	4,986,336	5,013,162
Other Charges	843,783	827,276	876,775	876,775	876,775
Fixed Assets	184,955	98,513	0	0	0
**Gross Expenditures	\$ 18,872,500	\$ 19,793,287	\$ 20,146,607	\$ 20,339,875	\$ 20,368,201
Less Intrafund Transfers	253,973	464,995	381,047	381,047	381,047
**Net Expenditures	\$ 18,618,527	\$ 19,328,292	\$ 19,765,560	\$ 19,958,828	\$ 19,987,154
General Fund Support (G.F.S.)	\$ 1,566,632	\$ 2,531,010	\$ 2,255,292	\$ 2,100,264	\$ 2,100,264

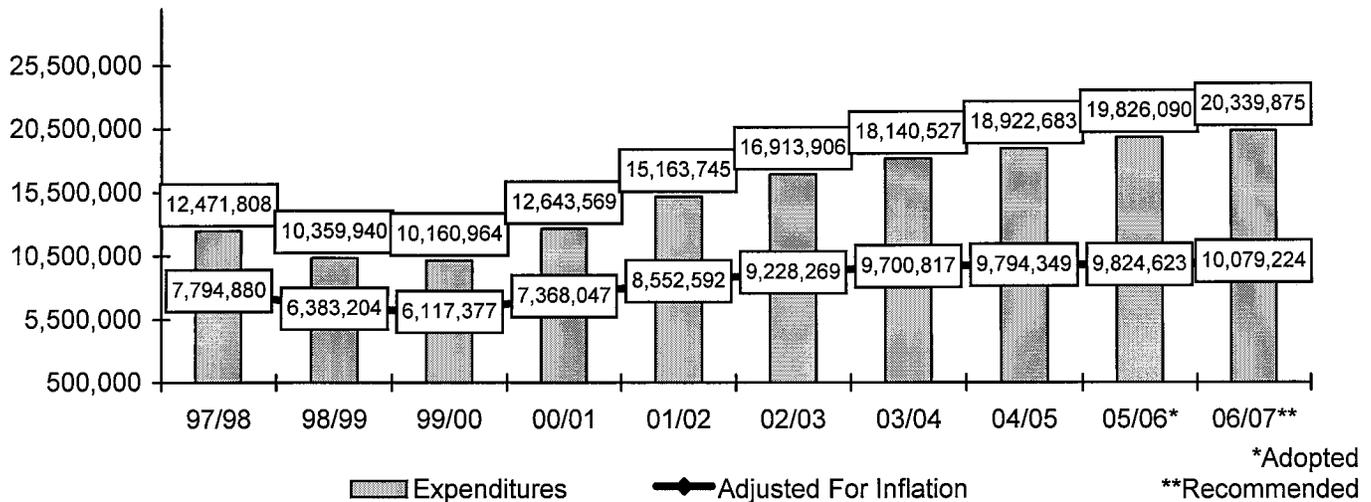
Number of Employees
(Full Time Equivalent)



Source of Funds



10 Year Expenditures Adjusted For Inflation



SERVICE PROGRAMS

Community Health Services

The Community Health Services Division works with the community to improve health by providing education, analysis, and direct prevention services. The Division administers programs of, tobacco prevention, AIDS prevention and case management, public health laboratory, vital records and law enforcement medical care.

Total Expenditures: \$4,713,284 Total Staffing (FTE): 33.0

Environmental Health Services

The Environmental Health Division is responsible for protecting public health by preventing exposure to toxic substances, disease, unsanitary conditions and other environmental hazards.

Total Expenditures: \$2,997,124 Total Staffing (FTE): 26.5

Family Health Services

The Family Health Services Division provides a variety of health services to the residents, including clinical, immunizations, communicable disease surveillance and control, comprehensive case management, parenting, counseling, educational and follow-up health services.

Total Expenditures: \$10,245,491 Total Staffing (FTE): 88.25

Public Health Administration

Administrative and fiscal oversight for all Public Health divisions including Health Systems and the Law Enforcement Medical Care Program. Enforcement of health and safety codes, protecting and preserving the public health as well as personnel management, procurement functions, contract administration, facilities management and information systems support are included.

Total Expenditures: \$2,383,976 Total Staffing (FTE): 15.0

DEPARTMENT COMMENTS

KEY ACCOMPLISHMENTS FOR THE PUBLIC HEALTH DEPARTMENT

CUSTOMER SERVICE

Public Health has increased the services and information provided to the entire population by:

- Developing a hotline for information on current health issues such as the whooping cough outbreak and flu vaccine services;
- Providing information and services to clients with limited English proficiency by hiring bilingual staff and providing informational documents in Spanish as well as English;
- Expanding the information on the website and reorganizing the information into a service-oriented format.

Public Health, along with the collaboration of multiple community partners, facilitated the planning and development of a Children's Assessment Center to evaluate, refer, and treat young children showing early signs of emotional or social development problems.

Goals for FY 06-07:

- 1) Improve opportunities for Medi-Cal recipients for specialty care and for a "medical home" through implementation of Medi-Cal Managed Care by June 30, 2007.
- 2) Expand the utility of the website through access to more program information, credit card payment for more services, and the ability to submit application/forms online.
- 3) Assist in implementation of a syringe exchange program to reduce the incidence of HIV, AIDS and Hepatitis C.

INTERNAL BUSINESS IMPROVEMENTS

Automation has reduced the number of hours staff spend documenting processes and services:

- Tablet computers are used in the field by HAZMAT Environmental staff to perform and document inspection findings and provide a copy on site to the inspected facility.
- Increased use of the County Immunization Registry by physicians and schools facilitates appropriate immunizations and avoidance of repeat unneeded immunizations.
- Forms, links, and payment for increasing number of services are available through the website, streamlining the flow of accurate information with reduction in staff time.

Goals for FY 06-07:

Major goals in the coming year will be to expand the use of automated field inspection systems and to increase the utility of the website to perform transactions.

FINANCES

The Public Health Department has taken multiple steps to ensure that services are provided at the least cost possible:

- The Public Health Lab expanded its client base in the community, thereby increasing testing volume and revenue, reducing the net County cost for that cost center.
- The operation of the clinical lab was analyzed, and its closure was recommended and approved. Through the County's existing contract with Community Health Centers, a private lab is providing these clinical lab services, eliminating the \$552,000 General Fund subsidy.
- Additional Public Health and other County departments have been added to the Medi-Cal Administrative Activities (MAA) claiming process, obtaining more federal money that supports existing or augmented activities to link services to Medi-Cal recipients, thereby improving health and offsetting General Fund support by leveraging outside resources.

Goals for FY 06-07:

- 1) Evaluate fees to maximize client support of Public Health activities where this would not jeopardize participating in programs that protect public health and safety.
- 2) Continue to leverage non-County funds to increase services to clients with health needs. Increase Medi-Cal Administrative Activities revenue by 5% by adding new organizations into the claims process.
- 3) Identify grant opportunities and apply for funds that enhance the public's health.

LEARNING AND GROWTH

- Public Health successfully used the "train the trainer" methodology to incorporate the new Enterprise Financial System for fiscal and personnel tracking.
- Staff in two divisions was cross-trained to allow redirection for response to unexpected and disaster situations. Duplication of inspectors has been avoided by sending one employee to perform multiple inspection services.

Goals for FY 06-07:

- 1) Implement High Performance Management System by July 1, 2007.
- 2) Increase awareness of Public Health and County communitywide results and indicators by 20% as measured by the Employee Opinion Survey and assist each employee to link their work to one or more County communitywide goals.
- 3) Increase the communication of Public Health activities and results with staff and community by expanding the quarterly Public Health bulletin to a larger audience, including all Public Health staff.

RECOMMENDED BUDGET AUGMENTATION REQUESTS AND RELATED RESULTS

Unit /Amount	Description	Results
Gross: \$103,181 General Fund Support: \$0	0.5 Public Health Nurse 0.5 Senior Public Health Nurse The purpose of the Children's Assessment Center is to identify the use of alcohol or drugs during pregnancy, which can significantly impact the development of a child. The assessment center will assess, develop a treatment plan, and provide access to services for children ages zero to five who are at risk for developmental or mental health problems.	These positions are proposed in order to support the Children's Assessment Center. The Economic Opportunity Commission will oversee the operation of this center and will contract with the Department of Public Health for the positions noted. The assessment center has a number of targeted results, a few of which are noted here (for additional explanation of the assessment center see the comments noted below). <ul style="list-style-type: none"> o 450 children will be screened into the center in the first full year of operation. o 100% of children will be assessed within 30 days of intake. o 95% of a random sample of children will have <i>Ages & Stages Questionnaire</i> scores that indicate improvement. o 75% of a random sample of children will demonstrate improvement as measured by standardized instruments and clinical assessment.
Gross: \$102,293 General Fund Support: \$0 Funded with Administrative Enforcement Order revenue	1.0 Environmental Health Specialist to support the Certified Unified Program Agency (CUPA), which monitors facilities and businesses with respect to hazardous waste and enforces corrective actions for violations.	<ul style="list-style-type: none"> • Implement the Universal Waste Program • Increase program inspections by 300 facility inspections in the first year (increasing to 350/year after training is complete). • Return the violation correction rate to better than 90%. • Increase Administrative Enforcement Order collections by 15%.
Gross: \$35,286 General Fund Support: \$0 Funded with Bioterrorism and MediCal Administrative Activity revenue	Increase a limited term 0.5 Administrative Services Officer position to 1.0 to support Bioterrorism, MediCal, and Health Agency wide reporting.	<ul style="list-style-type: none"> • State mandated Bioterrorism reporting requirements will be met. • New reports will continue be established in the County's relatively new SAP financial system in order to support the Health Agency's many reporting requirements to a number of state and federal agencies.
Gross: \$25,289 General Fund Support: \$0 Funded with State CCS revenue	Add a 0.25 Physical/Occupational Therapist II position to support the California Children's Services (CCS) program. This position will serve as the liaison between the County, the Special Services Division of the Department of Education, and the Department of Health Services.	<ul style="list-style-type: none"> • Comply with the terms of the Interagency Agreement between the Department of Health Services and the California Department of Education. • Coordinate Medical Therapy • Avoid having a therapist who treats patients perform this mandated activity. If this were to occur, a private practitioner would have to provide the service at a cost to the County of \$25,700. Thus, this budget augmentation will result in a cost avoidance of \$25,700.

Unit /Amount	Description	Results
Gross: \$51,238 General Fund Support: \$0 Funded with MediCal Administrative Activity (MAA) revenue	Add a 1.0 Accounting Technician to support billing and reporting activities for the MediCal Administrative Activity, and Targeted Case Management program.	<ul style="list-style-type: none"> Will reduce the amount of time spent by the Program Coordinator on reporting and billing, thereby allowing the Program Coordinator to conduct audits. Currently, auditing requirements are not being met and MediCal funding is at risk. Enable 8 new claiming units to receive MediCal revenue (a claiming unit is a County department, school, or community based organization). All MAA revenue claims must pass through the Public Health Department.

COUNTY ADMINISTRATOR'S COMMENTS AND RECOMMENDATIONS

The level of General Fund support is recommended to increase by approximately \$250,000 or 13%. Total revenues are flat as they are budgeted to increase by approximately \$165,000 or less than 1%. The increase in General Fund support is necessary in order to keep up with inflationary and other programmatic increases as total expenses are budgeted to increase approximately \$420,000 or 2%. The budget augmentation requests (BARs) that are noted above are revenue offset and do not increase the level of General Fund support for Public Health.

The California Children's Services (CCS) program is significantly impacting the revenues and level of General Fund support for this fund center. In FY 05-06, State revenue for the CCS program was over budgeted by approximately \$500,000. The updated revenue projections for the 06-07 fiscal year include a \$380,000 or 24% reduction as compared to 05-06. Options other than increasing the level of General Fund support for this program for 06-07 were evaluated, however, they would have resulted in the closure of several of the Medical Therapy Units and a major reduction in the services provided to children. Hence, the program cuts are not recommended as part of this budget. Public Health staff is continuing to review and analyze the financial and programmatic mandates related to this program in order to better determine the level of General Fund support required in the future.

In addition to the higher level of General Fund support, it is recommended that \$360,989 of Social Services Sales Tax realignment revenue also be utilized to mitigate revenue losses and expenditure increases in Public Health. Based upon caseload growth statistics produced by the State, \$172,500 of Social Services Sales Tax realignment revenue should be allocated to the CCS program. Hence, \$188,489 is provided above the minimum requirement. Note that the Public Health department believes the caseload statistics for the CCS program are understated and they are planning to address this concern with the State.

As noted in the first budget augmentation above, a new Children's Assessment Center will begin operating during the 06-07 fiscal year. The center is the result of collaboration between many members of the community including members of the County Board of Supervisors, several County Department Heads and staff, several community based organizations, and Dr. Ira Chasnoff and Associates. In summary, the purpose of the assessment center is to identify the use of alcohol or drugs during pregnancy, which can significantly impact the development of a child. The assessment center will assess, develop a treatment plan, and provide access to services for children ages zero to five who are at risk for developmental or mental health problems. The Economic Opportunity Commission will serve as the lead agency for the operation of the center. The center has many sources of funding, including money from the County General Fund in the amount of \$500,000 over two years.

Lastly, the entire Health Agency is in the midst of a reorganization, which is proposed to take effect at the start of the 06-07 fiscal year. The reorganization will result in savings of just under \$200,000 in salaries and benefits. The changes to the staffing plans for the Health Agency are reflected in the Public Health, Mental Health Services, Drug & Alcohol Services, and County Medical Services Program fund centers. As a result, there are a number of staffing changes. The changes to Public Health's position allocation is as follows:

- Eliminate a 0.5 Accounting Technician that supported the Clinical Laboratory. The Clinical Laboratory was closed as of 3/31/2006.

- Add a 1.0 Accounting Technician to support MediCal Administrative Activity (per budget augmentation noted above).
- Eliminate 1.0 limited term Department Automation Specialist position due to reduced Bioterrorism funding.
- Eliminate 2.0 Public Health Nurse positions in the Family Services division due to reduced grant funding.
- Eliminate a 0.5 Social Worker II position in the Family Services division due to reduced grant funding.
- Eliminate a 1.0 Community Health nurse position in the Children's Health and Disability Prevention division due to reduced grant funding.
- Add a 1.0 Environmental Health Specialist to support the Certified Unified Program Agency (per budget augmentation noted above)
- Change a limited term 0.5 Administrative Services Officer position to a 1.0 limited term position to support MediCal Administrative Activity and Bioterrorism program reporting (per budget augmentation noted above).
- Change a Patient Services Representative position in the AIDS division from 0.5 to 1.0 in order to reflect the actual hours worked.
- Add a 0.25 Physical and Occupational Therapist position to the CCS division in order to serve as a liaison to County schools (per budget augmentation noted above).
- Change a 0.5 Public Health Nutritionist position to 0.75 and add a 0.25 Public Health Nutritionist position. These changes are proposed in order to replace an equivalent amount of temporary help that will no longer be utilized because the work is of an ongoing nature.
- Add a 0.5 Public Health Nurse position to support the Children's Assessment Center (per budget augmentation noted above).
- Add a 0.5 Senior Public Health Nurse position to support the Children's Assessment Center (per budget augmentation noted above).
- Add a 1.0 Deputy Director position per the Health Agency reorganization.
- A limited term 1.0 Aids Program Coordinator position has been changed to a limited term 1.0 Program Coordinator I position per the Health Agency reorganization.
- A 1.0 Director of Health Promotion Services position has been changed to a 1.0 Program Coordinator II position per the Health Agency reorganization.
- A 1.0 Director of Public Health Nursing position has been changed to a 1.0 Division Manager position per the Health Agency reorganization.
- A 1.0 Director of Environmental Health position has been changed to a 1.0 Division Manager position per the Health Agency reorganization.
- A 1.0 Health Agency Administrator III position has been changed to a Division Manager position per the Health Agency reorganization.
- A 1.0 Health Agency Administrator III position has been changed to an Administrative Services Manager position per the Health Agency reorganization.
- A 1.0 Health Agency Administrator I position has been changed to a Program Coordinator II position per the Health Agency reorganization.

- A 1.0 Administrative Assistant III position has been changed to a 1.0 Department Personnel Technician position per the Health Agency reorganization.

BOARD ADOPTED CHANGES

The Board adopted the supplemental budget document item (pg. S-21 of the supplemental budget document), which increases the total budget by \$28,326 in order to accommodate a grant that is related to the disposal of waste tires.

Also, the Board adopted the supplemental budget document item (pg. S-30 of the supplemental budget document), which changes 2.0 Program Coordinator I, II positions to 2.0 Program Manager I, II positions and a 1.0 limited term Program Coordinator I position to a 1.0 limited term Program Manager I position. This change reflects the changes to this job classification as adopted by the Civil Service Commission at its April 27, 2006 meeting.

GOALS AND PERFORMANCE MEASURES

Department Goal: Prevent epidemics and the spread of disease or injury.						
Communitywide Result Link: Healthy Community.						
1. Performance Measure: Annual rate of reported retail foodborne disease outbreaks per 100,000 people.						
01-02 Actual Results	02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Adopted	05-06 Actual Results	06-07 Target
0	*2	**3	0.7	1	0.4	1
<p>What: Measures the number of reported foodborne outbreaks originating from food retail sources as a rate per 100,000 population. A foodborne outbreak is defined as “the occurrence of 2 or more cases of a similar illness resulting from ingestion of a common food source.”</p> <p>Why: The Public Health Department responds to foodborne disease outbreaks in order to identify the cause and, if possible, prevent it from reoccurring. Investigating and controlling foodborne disease outbreaks minimizes the number of people affected and reduces the potential for recurrence, contributing to maintaining a healthy community.</p> <p>How are we doing? There was one reported foodborne disease outbreak for fiscal year 2005-06 in San Luis Obispo County, which translates to a rate of 0.4 per 100,000 population (based on a population estimate of 263,242 as of January 1, 2006; California Department of Finance). This rate is well under the adopted target for 2005-06, and is lower than the result for 2004-05. Benchmark data from other counties are not available.</p> <p>This outbreak originated in a commercial restaurant and had three probable victims. However, the outbreak was associated with a histamine release in fish normally associated with food handling during packaging, so the restaurant itself was not to blame for the illness. The product was pulled immediately from the restaurant, preventing further illness in the community. The investigation of outbreaks gives the Health Department invaluable practice in outbreak investigation and management, thus better preparing us for other public health emergencies.</p> <p>* In fiscal year 2002-03, there were two identified retail foodborne disease outbreaks. This was inadvertently reported as two cases rather than being translated into the number of outbreaks per 100,000 population, which would have been a rate of 0.8.</p> <p>** In fiscal year 2003-04, there were three identified retail foodborne disease outbreaks. This was inadvertently reported as three cases rather than being translated into the number of outbreaks per 100,000 population, which would have been a rate of 1.1.</p>						

2. Performance Measure: Cost per visit for childhood immunization.						
01-02 Actual Results	02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Adopted	05-06 Actual Results	06-07 Target
New Measure	\$ 44.00/ visit	\$ 56.38/visit	\$ 29.73/ visit	\$ 31.00/ visit	\$38.34/ visit	\$ 41.00/ visit
<p>What: Measures the cost to immunize a child at County clinics per visit. Does not include flu clinic and vaccinations for persons traveling overseas. Cost is direct division cost, minus revenue.</p> <p>Why: To monitor efficiency of delivering this important and heavily utilized service. Centers for Disease Control (CDC) information states that for every dollar spent on immunizations the following is saved in future medical costs: measles, mumps, rubella (MMR) - \$16.34, diphtheria, pertussis, tetanus (DPT) - \$6.21, Chickenpox - \$5.40.</p> <p>How are we doing? The average cost per visit for childhood immunization in 2005-06 was \$38.24. This cost is higher than the adopted goal of \$31.00/visit. The 2005-06 adopted target was based on less accurate 2004-05 data due to revenue being mixed between cost centers. The actual results are very close to a re-projection of average cost done at the end of the first quarter of this fiscal year, which was \$40.72/visit. Benchmark data from other counties are not available.</p> <p>In fiscal year 2005-06 there were 1,897 childhood immunization visits, a 17% decrease from the 2,289 visits in 2004-05. This is expected as more children are being seen by pediatricians, CHCCCs, and through Healthy Families rather than through the County clinics. Cost per visit is also reflective of the clerical time to register, collect payment and record the visit and the RN time to screen and give an average of 2.2 shots per visit. Overall program net cost increased \$4,484 (or 3.7% of total expense).</p>						
3. Performance Measure: Percentage of low birth-weight infants.						
01-02 Actual Results	02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Adopted	05-06 Actual Results	06-07 Target
5.0%	5.1%	5.5%	5.5%	5.0%	*5.9%	5.9%
<p>What: Measures the percentage of live born infants born to county residents (averaged over a three-year time period) who weigh less than 2,500 grams (five and three-quarters pounds) at birth.</p> <p>Why: Low birth-weight impacts the infant's survival and future development. Reducing the percentage of low birth weight infants would decrease costs for neonatal survival and enhance infant quality of life and survival. Several Family Health Services programs strive to decrease teen pregnancy, enhance nutrition, decrease tobacco use, decrease alcohol use and encourage early entrance into prenatal care in order to improve mothers' health and decrease infant low-birth rate.</p> <p>How are we doing? Per the 2006 County Health Status Profiles, the percentage of low birth-weight infants among San Luis Obispo County residents in 2002-2004 was 5.9 (with 95% confidence limits of 5.0% to 6.9%). Our results were better than the California rate of 6.6, and also better than the rates of four of the seven benchmark counties (Santa Cruz – 5.4, Placer – 5.6, Napa – 5.7, Monterey – 6.0, Ventura – 6.4, Santa Barbara – 6.6, and Kern - 6.8).</p> <p>The actual result for 2005-06 is higher than our adopted target, which was based upon the Healthy People 2010 national target of 5%. SLO County and state level data show a slightly increasing trend in the percentage of low birth weight infants over the last five years, rendering the 5% target very ambitious. We believe that our public health programs (outreach, including health fairs on the importance of prenatal, and assistance to enroll in Medi-Cal) care are contributing to our comparatively lower percentage of low birth-weight infants,</p> <p>* FY 2005-06 Actual Results are the most recent data available (i.e., the average percentage of low birth-weight infants for Calendar Years 2002-2004 as reported in 2006 County Health Status Profiles).</p>						
4. Performance Measure: Percentage of live born infants whose mothers received prenatal care in the first trimester.						
01-02 Actual Results	02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Adopted	05-06 Actual Results	06-07 Target
82.6%	82.9%	81%	82.4%	85%	*82.7	85%
<p>What: Percentage of live born infants, born to county residents, whose mothers received prenatal care in the first trimester of pregnancy.</p> <p>Why: Early, high quality prenatal care reduces the incidence of morbidity and mortality for both mother and infant.</p>						

How are we doing? Per the 2006 County Health Status Profiles, the percentage of live born infants whose mothers received prenatal care in the first trimester was 82.7 (with 95% confidence limits of 81.1% to 84.4%). This percentage is lower compared to California, 86.4%, and compared to five of our seven benchmark counties: Santa Cruz – 90.7%, Ventura – 90.1%, Placer – 89.8%, Kern – 83.9%, Monterey – 83.7%, Santa Barbara – 82.0%, and Napa – 80.3%.

Our 2005-06 actual results are lower than the adopted target of 85%; however, we have steadily climbed each year and continue to work towards meeting the target of 85%. An increasing proportion of county births are among Hispanic women. Hispanic women have had comparatively lower early PNC utilization rates than to white or Asian women, yet data from 2003 show that the rate among Hispanic women in the county is improving (FHOP 2006). Also, based on feedback from some health care providers and pregnant women, one of the key issues impacting this performance measure is reduced access to medical care. For example, a couple of OB/GYNs have retired and pregnant women are transitioning to other physicians or CHCCCs. Previously transportation was an issue, yet CHCCC includes transportation as part of its services and the Department offers bus vouchers.

* FY 2005-06 Actual Results are based on the most recent data available: 2006 County Health Status Profiles using data from calendar years 2002-2004.

Department Goal: Promote and encourage healthy behaviors.

Communitywide Result Link: A Healthy Community

5. Performance Measure: Birth rate of adolescent females, ages 15 to 17, per 1,000 population.

01-02 Actual Results	02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Adopted	05-06 Actual Results	06-07 Target
11.6	13.4	13.0	10.6	12.0	11.5	11.0

What: This measures the frequency of teen births - presented as a rate per 1,000 female county residents between 15 and 17 years old.

Why: The rate of teen births in our county is a direct predictor of future health, social and economic status. The age range of 15 to 17 year olds is a critical one and a direct indicator of future high-risk families.

How are we doing? Based on teen birth data for calendar year 2005 (AVSS), the birth rate was 11.5 per 1000 females 15-17 years old. This rate exceeds our adopted target for the year. Due to lateness in statewide reporting, 2005 data from the benchmark counties are not yet available. Using data from 2004, San Luis Obispo County had the second lowest teen birth rate compared to our benchmark counties: Placer 5.5, SLO 10.5, Napa 13.6, Santa Cruz 20.5, Santa Barbara 26.3, Monterey 29.8, and Kern 36.3. One reason for Placer County has a smaller Hispanic population, which likely contributes to their lower rate of teen births.

While this rate is lower than the adopted target for 2005-06, it is also slightly higher than the actual results for 2004-05. It should be noted that due to the low number of teen births in the county, annual rates can vary without signifying real change. Teen births rates are influenced by ethnicity. In 2003, 15-17 year teens of Hispanic origin had a fertility rate of 34.3/1000 compared to 7.1/1000 among non-Hispanic whites in the county. Several county programs are working together to help reduce the birth rate, especially among Hispanic teens.

*2005-06 denominator is based on average of Department of Finance population projections, by age, for 2005.

6. Performance Measure: Percentage of the State allocated caseload enrolled in the Women, Infants & Children (WIC) Program.

01-02 Actual Results	02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Adopted	05-06 Actual Results	06-07 Target
97%	97.2%	97%	97.3%	97%	97.8%	98%

What: Measures the number of women, infants and children receiving supplemental foods, nutrition education and linkages to good health care as a percentage of the allocated caseload. Allocated caseload is determined by the State WIC Branch and is based on a compilation of information which includes, but is not limited to census data, county demographics, past performance, etc.

Why: The components of the WIC Program reduce the complications of pregnancy; reduces iron deficiency anemia in women, infants and children; decreases the incidence of low birth-weight infants and promotes optimum growth and development of infants and young children. Ensuring high program participation enhances the health of low-income women, infants and children.

How are we doing? In San Luis Obispo County, the monthly average number of women, infants and children participating in the WIC program for fiscal year 2005-06 was 4,400; or 97.8% of the eligible caseload. This coverage rate is higher than fiscal year 2004-05 and higher than the adopted target for this year. Participation for same time period in the benchmark counties was: Kern - 48,143 (98.2%); Monterey - 20,279 (98.8%); Napa - 3,784 (101.6%); Placer - 3213 (100.4%); Santa Barbara - 16,094 (99.5%); Santa Cruz - 8111 (101.1%); Ventura - 22,548 (101.1%); Statewide - 1,309,939 (97.2%).

2005-06 actual results exceeded the adopted result for the fiscal year and is within the state mandated participation of 97-100% of allocated caseload. Since fiscal year 2001-02 the San Luis Obispo County WIC program monthly allocated caseload has grown 3% (from 4375 to 4,500). Despite the increase in caseload, there has been an incremental increases in the percentage of caseload participation over the same time period and is reflective of WIC service accessibility (eight WIC clinic site locations serving San Luis Obispo County), evening hour appointments, ability to mail food vouchers to families with transportation problems, and the local agency's liberal walk-in policy at all clinic sites.

7. Performance Measure: HIV positive antibody test rate among community residents per 100,000 population.

01-02 Actual Results	02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Adopted	05-06 Actual Results	06-07 Target
2.4	3.2	2.1	*2.7	2.8	4.6	3.2

What: Measures the number of positive Human Immunodeficiency Virus (HIV) antibody tests as a rate per 100,000 population. Testing is done in the Public Health Lab from specimens submitted from HIV test sites in the community and in the Public Health Department, but not those from the California Men’s Colony.

Why: The rate of HIV positive antibody tests in the population reflects the increased availability and accessibility of testing services and the efforts to get people to test that are at high risk for contracting HIV.

How are we doing? During fiscal year 2005-06, the HIV positive antibody test rate was 4.6 /100,000. The CA Department of Finance population estimate for (January 1) 2005 of 263242 people was used to calculate the rate. This rate is higher than the adopted target for 2005-06 and higher than the actual results for 2004-05*. Comparable benchmark data from other counties are not available.

There were a total of 12 positive tests during the fiscal year, which is higher than expected yet positively reflects the serious outreach efforts to encourage high-risk individuals to get tested, including the using the 20-minute rapid oral test to provide faster results. As anticipated in the program, there will be more positive tests from high-risk individuals than from the general population. The number of duplicative test results has not been measured but has been estimated to be a small number. The data will become more accurate as HIV reporting by name laws are fully implemented in California. The implementation is expected to take place in 2007 when the development of State reporting policies and procedures are completed.

* The population estimate was revised for 2004-05, resulting in a rate recalculation to 2.7 from 2.5.

8. Performance Measure: Youth smoking rate (proportion of youth in 11th grade who have smoked cigarettes within the past 30 days).

01-02 Actual Results	02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Adopted	05-06 Actual Results	06-07 Target
22%	22%	*19%	*19%	18%	NA	17%

What: The proportion of youth in the 11th grade who have smoked cigarettes within the past 30 days, based on the county schools survey done biannually.

Why: Among young people, the short-term health consequences of smoking include respiratory and non-respiratory effects, addiction to nicotine, and the associated risk of other drug use. Long-term health consequences of youth smoking are reinforced by the fact that most young people who smoke regularly continue to smoke throughout adulthood. Teens who smoke are three times more likely to use alcohol, eight times more likely to use marijuana and 22 times more likely to use cocaine.

How are we doing? The latest Healthy Kids Survey, conducted in 2005, was expected to be released in the summer of 2006. However, due to difficulties in report finalization, this report will not be available until late 2006. The 2005 data should be available for inclusion in the 2007-08 budget preparation process. The most recent youth smoking rate data for San Luis Obispo County are from the Healthy Kids Survey conducted in 2003. These results were reported as actual results in both 2002-03 and in 2003-04:19% of all 11th graders reported having smoked cigarettes in the past 30 days. This is a decline from 22% in 2001.

Using 2003 data, Kern - 15%; Monterey - 13%, Santa Barbara - 16%, and Santa Cruz County - 18%. The other benchmark counties did not have comparable data. The most recent California Student Tobacco Survey data, 2003-04, for 11th graders showed a statewide percentage rate of 14.8%. The national Youth Risk Behavior Survey – among 9-12th graders - results were 23% in 2005, a decrease from 24% in 2004.

* The FY 2003-05 and 2004-05 Actual Results are from the 2003 survey (the most recent data available).

9. Performance Measure: Adult smoking rates.

01-02 Actual Results	02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Adopted	05-06 Actual Results	06-07 Target
*16.3%	**13.4%	**13.4%	***16.0%	12.5%	NA	15.5%

What: The proportion of adults who smoke based on the California Health Interview Survey (CHIS), which is completed bi-annually. *Note: Replaced Action for Healthy Communities survey with California Health Interview Survey, which is being completed every 2 years and has benchmark data for each county and the State. Both surveys utilized random telephone surveys. In the 2003 Action for Health Communities Survey, 500 San Luis Obispo County residents were contacted and the 95% confidence interval for the results was approximately +/- 4.5%. In the 2003 California Health Interview Survey, 506 San Luis Obispo County residents were contacted and the 95% confidence interval for the results was approximately +/- 4.1%.*

Why: The Centers for Disease Control reports that, in addition to the well known association with lung cancer, cigarette smoking also increases the risk for heart disease and stroke. On average, someone who smokes a pack or more of cigarettes per day lives seven years less than someone who never smoked.

How are we doing? The 2005-06 adult smoking rate data was expected to be obtained from the latest California Health Interview Survey (CHIS), conducted in 2005 and due for release in the summer of 2006. However, due to difficulties in report finalization, this report will not be

available until late 2006. The 2005 data should be available for inclusion in the 2007-08 budget preparation process. The results reported in 2004-05; 16% of adult smoke cigarettes, are from the 2003 California Health Interview Survey (CHIS) showed slightly different results compared to the 2003 Action for Healthy Communities survey, 13.4%. Such differences are expected with different samples and are within each survey's margin of error.

Per the 2003 CHIS, the percentage of adults who were current smokers were: California – 16.5%, San Luis Obispo County – 16.0% (95% confidence interval = 11.9 – 20.1), Kern County – 22.4%, Monterey / San Benito County – 16.5%, Placer County – 15.4%, Napa County – 14.5%, Santa Barbara County – 14.3, Santa Cruz County – 13.8, and Ventura County – 13.4. Because of the relatively wide confidence intervals (plus or minus 3-4% for each of the benchmark counties), variations in the county CHIS results from 2001 to 2003, and differences among benchmark counties may be due to "chance" rather than a true difference in actual smoking rates. The national smoking prevalence in 2004 was 20.9% (per the Behavioral Risk Factor Surveillance System).

* The results for FY 2000-01 and FY 2001-02 were from the 1999 and 2001 Action for Healthy Communities Survey, respectively

** The results for FY 2002-03 and FY 2003-04 were from the 2003 Action for Healthy Communities Survey

*** The FY 2004-05 Actual Results are from the 2003 California Health Interview Survey (CHIS) (the most recent data available).

Department Goal: Protect against environmental hazards.

Communitywide Result Link: Safe and a healthy community.

10. Performance Measure: Percentage of compliance with State or Federal bacteriological drinking water standards.

01-02 Actual Results	02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Adopted	05-06 Actual Results	06-07 Target
95.2%	95.2%	95.3%	95.3%	96.0%	95.8%	96.0%

What: San Luis Obispo County regulates approximately 166 small water systems with 5-199 connections. These supply water to approximately 20% of our county. Water samples are tested for total coliform bacteria.

Why: Water systems contaminated with fecal material can cause diseases such as typhoid fever, cholera, shigella and cryptosporidiosis. By performing routine inspections for coliform bacteria on water systems and requiring repairs and improvements to water systems that repeatedly fail bacteriologic standards, we will improve the healthfulness of the drinking water supply, reduce the incidence of samples that fail bacteriological water tests and reduce the risk of disease.

How are we doing? During fiscal year 2005-06, 1,767 routine water samples were taken and 1,692 passed. This represents a passing compliance rate of 95.8%. This compliance rate has improved each year since 2001-02, and is nearly in line with our adopted target for 2005-06. Benchmark data from other counties are not available.

When a sample fails, the water system operator is notified immediately and instructed on how he can resolve the problem. Follow up samples are taken until they pass. Eventually, all water systems must pass bacteriological drinking water standards.

Department Goal: Promote accessible, appropriate and responsive health services to all members of the community.

Communitywide Result Link: A Healthy Community

11. Performance Measure: Number of children enrolled in the Healthy Families (HF) Program and in the Healthy Kids (HK) Program of the Children's Health Initiative

01-02 Actual Results	02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Adopted	05-06 Actual Results	06-07 Target
HF: 3,378	3,833	3,824	4,331	4,600	4,436	5,000
HK: N/A	N/A	N/A	N/A	N/A	557	750

What: Number of children, aged 0-19 years, enrolled in the Healthy Families Program and in the Healthy Kids Program

Why: Health coverage for all children ensures that children have access to preventative and curative health care for their own well-being and for the well-being of all children. The Healthy Families Program expands public health coverage to include children in families with incomes at

or below 250% of the federal poverty level. Through the Children's Health Initiative, the Healthy Kids Program offers health coverage to all children below 300% poverty who are ineligible for Healthy Families or Medi-Cal.

How are we doing? In San Luis Obispo County, the cumulative number of children enrolled in the Healthy Families Program* (as of June 2006) was 4,436; a 2.4% increase from the number enrolled as of June 2005. The result is lower than the adopted target for 2005-06, which was based on an anticipated increase rate of 10%. During the 12-month period ending June 2006, there were 1664 newly subscribed children and 1670 children who dis-enrolled in the Healthy Families Program.

Based upon the cumulative number, the number of children obtaining health insurance coverage through Healthy Families continues to increase despite not receiving state allocated outreach and enrollment funding (state funds were targeted toward counties with greater need). In 2005-06, San Luis Obispo County had about 7% of its total children, 0-19 years, enrolled in the program (based on Department of Finance population projection 2006 of 63,308 – including Cal Poly/Cuesta). For comparison, according to a 2003 survey, 5.8% of children in California were enrolled in Healthy Families (CHIS 2003). Statewide data as to reasons for dis-enrollment indicate that 66.8% of dis-enrollments are due to 'possibly avoidable' reasons (such as, enrollment information incomplete or not received, payment not received) and 33.2% are due to 'unavoidable' reasons (such as, child not eligible due to income too low, child reached 19 years of age, or requested termination). In San Luis

Obispo County it is expected that dis-enrollment is mostly due to children reaching 19 years of age or they have moved out of the county.

The enrollment for our benchmark counties (as of June 2006) was: Napa – 2,471 Placer – 3,416, Santa Cruz – 4,875, Santa Barbara – 8,575, Monterey – 15,981, Ventura – 16,975, and Kern 21,543. Note that enrollment numbers vary based on the county population and the percentage of children who qualify for the program.

The Children’s Health Initiative began enrolling children into the Healthy Kids Program in September 2005. By June 2006, 557 children had been enrolled and 331 were on the waiting list pending further program funding. Of those children enrolled, 197 were age 0-5 and 373 were age 6-18. As of June 2006, 13 children had dis-enrolled from the program.

As the program had just started, no adopted target was set for fiscal year 2005-06. The Healthy Kids program is well on track towards the 2006-07 target, yet the total number of enrolled children is limited by funding for older children, ages 6-18 years. Of the benchmark counties, Santa Cruz, Santa Barbara and Napa have established expansion programs for children’s health insurance; Kern County is in the planning stages.

The Children’s Health Initiative and Healthy Families Program (and Medi-Cal) staff are working very closely to reduce barriers to enrolling in Healthy Kids, Healthy Families and/or Medi-Cal for all children and ensure that all children have health coverage. In 2003, it was estimated that 4,000 children were uninsured in the county (CHIS 2003).

*All Healthy Families data is from the state website: www.mrmib.ca.gov.

**All Healthy Kids data is from the local Children’s Health Initiative office.

12. Performance Measure: Percentage of pregnant and parenting women with positive drug and alcohol screen or admitted substance abuse who are enrolled in Public Health Nursing Case Management Services and receiving follow-up.

01-02 Actual Results	02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Adopted	05-06 Actual Results	06-07 Target
91.3%	80.2%	73.1%	63.8%*	75%	49.4%	75%

What: Measures the percentage of pregnant and parenting women who are referred to Public Health Nursing Case Management Services for positive drug and alcohol screen or admitted substance abuse who are enrolled in Public Health Nursing Case Management Services.

Why: Alcohol, drugs or smoking during pregnancy can substantially affect newborn health and increase the healthcare costs associated with the newborn. The percentage is a measure of how well the program reaches and enrolls this very high-risk target population.

How are we doing? In fiscal year 2005-06, 49.4% of the 164 referred substance abusive pregnant/parenting women were enrolled into Public Health Nursing Case Management Services (PHNCMS). This percentage has decreased from fiscal year 2004-05 and is below the adopted target for 2005-06. Data from the benchmark counties are not available. However, compared to the national rate of 6% of women accepting referrals to drug programs, our rate remains high.

The enrollment rate is below the expected percentage of 75%. In the last couple of years, PHNCMS has lost 2 FTE field nursing staff due to budget cuts and 0.75 FTE as unfulfilled vacancy, greatly reducing caseload levels. Also, Public Health Nurses’ caseloads are also decreased by increased documentation requirements, i.e. mother and child(ren) now have separate charts requiring double charting. These are new funding source and county requirements. Considering staffing levels, this year’s target was ambitious. Of the identified women, 49.4% were enrolled, 26% were on the wait list for services, and 24% refused services or could not be located.

*Revised from previous report to exclude women on the wait list from the numerator in order to be comparable with the 2005-06 data.