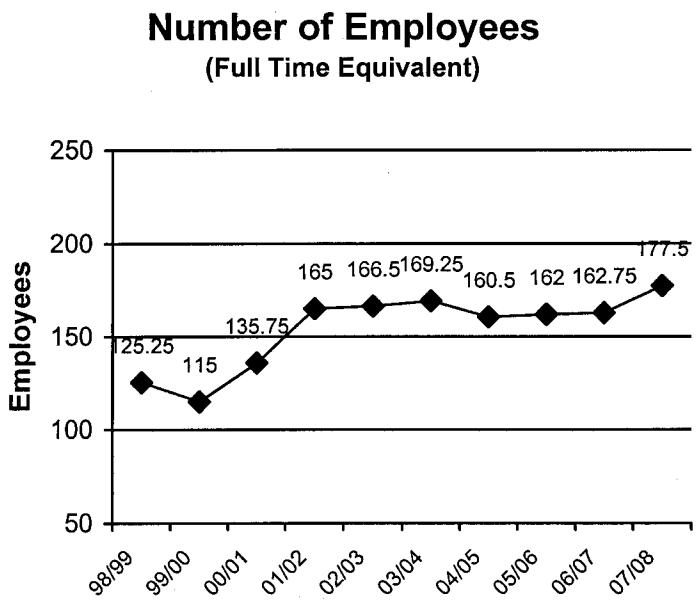
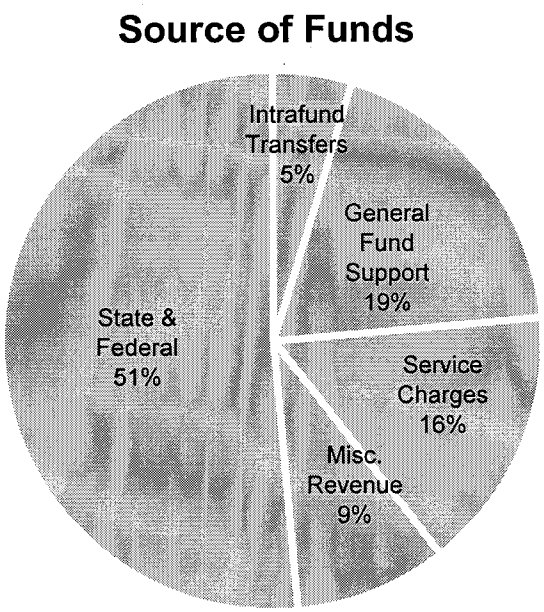
MISSION STATEMENT

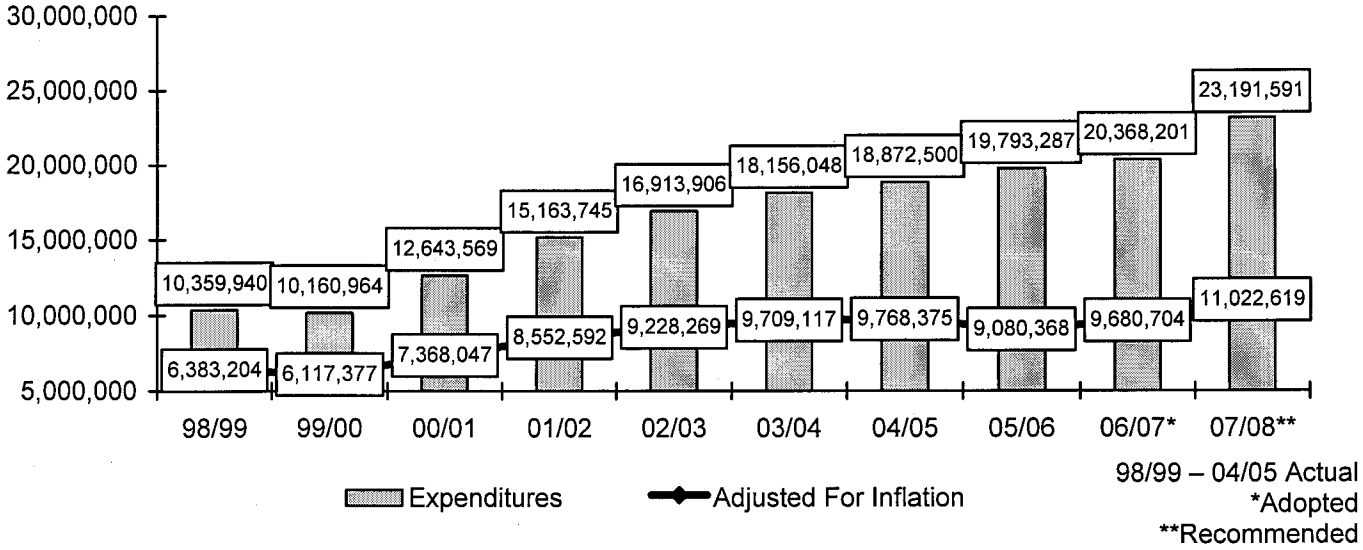
The San Luis Obispo County Public Health Department improves and maintains community health by identifying health issues, preventing disease and injury, influencing policy development and promoting healthy behaviors through leadership, collaborative partnerships, education, direct services, and surveillance.

Financial Summary	2006-07 Budget	2006-07 Projected	2007-08 Requested	2007-08 Recommended	Change From 2006-07
Revenues	$ 17,886,890	$ 17,640,849	$ 17,411,972	$ 17,740,887	$ (146,003)
Salary and Benefits	14,478,264	13,697,469	15,747,784	16,416,259	1,937,995
Services and Supplies	5,013,162	5,580,757	6,192,046	6,137,887	1,124,725
Other Charges	876,775	877,912	620,275	632,275	(244,500)
Fixed Assets	0	0	10,170	5,170	5,170
**Gross Expenditures	$ 20,368,201	$ 20,156,138	$ 22,570,275	$ 23,191,591	$ 2,823,390
Less Intrafund Transfers	381,047	341,895	1,099,527	1,099,527	718,480
**Net Expenditures	$ 19,987,154	$ 19,814,243	$ 21,470,748	$ 22,092,064	$ 2,104,910
General Fund Support (G.F.S.)	$ 2,100,264	$ 2,173,394	$ 4,058,776	$ 4,351,177	$ 2,250,913





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: $5,630,936 Total Staffing (FTE): 35.5

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: $3,208,487 Total Staffing (FTE): 28.5

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: $10,805,996 Total Staffing (FTE): 92.0

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 publics health as well as personnel management, procurement functions, contract administration, facilities management and information systems support are included.

Total Expenditures: $3,546,172 Total Staffing (FTE): 21.5

DEPARTMENT COMMENTS

KEY ACCOMPLISHMENTS

CUSTOMER SERVICE

- Responded to more than 500 citizen complains regarding food borne illness, vector infestations, hazardous waste discharge, etc.
- Implemented the new Medical Marijuana Identification Card (MMIC) Program effective 12/14/06, per State mandate.

- Implemented the new Electronic Death Registry System (EDRS), effective November 1, 2006. The web-based EDRS provides the ability for coroners, funeral directors, doctors and hospitals to submit requests for electronic death certificates 24 hours per day and makes them available to families more rapidly.
- Program staff assisted in the implementation of a syringe exchange program.
- Worked successfully to implement the Newborn Immunization Registry Project with three local hospitals that perform deliveries – over 900 babies have been added to the regional immunization registry.
- Public Health (PH), Mental Health (MH), and Drug & Alcohol (DAS) along with other community partners formed a working collaboration to successfully open a Children's Assessment Center called Martha's Place. The center will diagnosis and provide treatment plans and referrals for children who have been parentally exposed to drugs or alcohol.
- In FY 2006/07, PH staff began discussions with First Five staff to develop a MediCal Administrative Activity (MAA) claiming plan with the intent to begin actual claiming in FY 2007/08. By doing so, PH will increase revenue at minimum 5%.

Goals for FY 07-08:

1) Continue researching and analyzing sites to find people at high risk for HIV to test and provide counseling to reduce HIV transmission to others.
2) Improve opportunities for Medi-Cal recipients for specialty care and for a "medical home" through implementation of Medi-Cal Managed Care by January 1, 2008.

INTERNAL BUSINESS IMPROVEMENTS

- Inspection frequency in Retail Food Program has nearly doubled over FY 05-06 through setting clear priorities for meeting specified inspection targets, filling vacancies, training newly hired staff and increasing efficiency through the use of field computers.
- Organized and led teams to conduct multiple drills in Public Health Department:
  - Public Health Law: A Pandemic Influenza based tabletop drill exercising Health Officer legal authority authored by State
  - First large-scale drill of Public Health Department's Strategic National Stockpile (SNS) plan for a Point of Distribution (POD), with over 75 personnel trained in POD operations, and over 700 county personnel successfully vaccinated against flu in under 3 hours
  - Pandemic Influenza and SNS tabletop drill that exercised the administrative functions of the SNS plan with multiple other agencies in a training and tabletop environment
  - Participated in Statewide Medical Disaster drill
- Ongoing community education on the harmful effects of smoking, retail tobacco licensing, and how to create smoke free environments.
- Suspected Abuse Response Team (SART) changed to a digital photo documentation system. Exam photos are now saved on a secure, confidential SART server. This allows immediate access by medical staff, law enforcement or CWS. The images are now archived on CD, which allows for a more secure and easier storage and better maintains the quality of photos.

Goals for FY 07-08:

1) Transition to Envision Connect, a web-based database program. Currently, Environmental Health (EH) uses Envision as a server based system. This will further simplify the automated field inspection reports, further reducing the time for inspections. The web-based system allows for real time remote wireless field access to Envision. If access is successful, (limited by same access issues as cell phone access) field staff could work remotely and it would not be necessary to come into the office every day. This may ultimately lead to people going straight to the field from their homes further increasing field time. There are many issues that must be worked out but this all begins with the transition to Envision Connect.
2) The Tobacco Control Program will provide education, prevention and stop smoking opportunities to reduce the use of tobacco products and the harmful effects of secondhand smoke. Major efforts include: tobacco retail licensing to reduce youth access to tobacco products, 2) smoke free outdoor policies to reduce exposure to secondhand smoke, and 3) monitoring service delivery regarding the quality and effectiveness of contracted stop smoking services.

FINANCES

- Applied for and received a 3-year grant to assist Public Health and community partners in outreach, enrollment, retention and utilization of Healthy Families and Healthy Kids Programs.
- Applied for and received a planning grant from the California Endowment to increase Public Health and medical provider capacity to reduce obesity.

- Tobacco Control Program anticipates contracting out the majority of stop smoking services, rather than implementing all of the services internally, with the expectation the change will increase cost effectiveness.
- Due to having dedicated staff, PH passed the State audit in the MAA program. This was the first audit conducted in this program.

Goals for FY 07-08:

1) Find ways to provide low cost high-level customer service through the use of automation and staff training.
2) Increase Medi-Cal Administrative Activities revenue by 5% by adding new organizations into the claims process. Identify grant opportunities and apply for funds that enhance the public's health.

LEARNING AND GROWTH

- In Environmental Health, cross-trained staff in order to implement the generalist approach to service delivery.

Goals for FY 07-08:

1) Train Environmental Health staff on implementation of newly revised state food code.

KEY CHALLENGES

- 75% of this Public Health's budget unit's funding is obtained from Federal and State sources. County funds leverage these dollars and support core local Public Health activities such as communicable disease control. Federal and State budget challenges currently exist and may further impact public health progress in the coming year.
- Nursing shortage impacts the ability to fill vacancies with qualified staff and in a timely manner to maintain services following a staff vacancy.
- Integrating multiple databases to reduce data entry, and provide better information regarding response to public health issues, measure inspector productivity, and follow up quickly with enforcement, when it is required. In addition, be able to meet public information requests and provide decision makers with accurate, dependable data for the budget process, establishing goals and priorities, and tracking program impacts.

COUNTY ADMINISTRATOR'S COMMENTS AND RECOMMENDATIONS

The level of General Fund support for the Public Health Department is increasing by a whopping $2,250,913 (107%). The large increase is due to a structural budget imbalance as state, federal, and grant revenues are not keeping pace with the cost of providing mandated programs. If the increase of General Fund support were not supported, significant reductions to service levels and programs would occur. Some examples of avoided reductions to programs include disease outbreak response, tuberculosis prevention, and family planning and cancer screening.

Total expenses are recommended to increase $2,104,910 (10%), which essentially support existing staffing levels plus the additional positions listed below in the budget augmentation request section. The 3.5% increase in pension related expense increases the department's salary and benefit accounts by $335,482. It is worth noting that in the aggregate, the budget augmentations recommended for approval actually reduce the level of General Fund support by $182,069 (i.e. if these augmentations are not approved, the level of General Fund Support will increase from $2,250,913 to $2,432,982).

Total revenues are decreasing by $146,003 or less than one percent. The majority of the sources of revenue are flat or decreasing slightly. However, of particular note is that Health Vehicle License Fee Realignment revenue is budgeted $737,118 lower than in FY 2006-2007. This revenue was under realized in FY 2005-2006 and FY 2006-2007 and the reduced amount for FY 2007-2008 should be more accurate.

The changes to the position allocation for this fund center are as follow:

- +2.0 Public Health Microbiologists per the budget augmentation request noted below.
- +0.5 Sr. Account Clerk per the budget augmentation request noted below.
- +0.25 Public Health Nurse per the budget augmentation request noted below.
- +1.0 Physical/Occupational Therapist II per the budget augmentation request noted below.

- +1.0 Patient Services Representative per the budget augmentation request noted below.
- +2.0 Environmental Health Specialists per the budget augmentation requests noted below.
- -0.5 limited term Community Health Nurse due to the loss of grant funding.
- 7.0 limited term positions are recommended to become regular permanent positions due to the long-term nature of the programs.
- +2.0 Department Personnel Technicians transferred from the Mental Health Department (fund center 161) pursuant to the Health Agency reorganization in which all departmental information technology and personnel functions will be centralized within the Public Health fund center.
- +4.5 Department Automation Specialists (2.0 transferred from the Mental Health Department, 2.0 from the Drug & Alcohol Services Department, and 0.5 from the County Medical Services Program) pursuant to the Health Agency reorganization in which all departmental information technology and personnel functions will be centralized within the Public Health fund center.
- -1.0 limited term Emergency Services Coordinator and +1.0 Program Manager II in order to meet the needs of the Bioterrorism program

Lastly, there are three budget augmentation requests, which are not recommended for funding. The Department Automation Specialist position is not recommended for funding as a new Technology Supervisor position was added to the department mid FY 2006-2007 and it is recommended that a complete assessment of the technology needs of the department be conducted prior to the addition of new positions. The 0.5 Social Worker position I/II position is not recommended, as the associated results did not warrant the additional level of General Fund support. The 1.0 Health Education Specialist is not recommended because the report from the Obesity Prevention Taskforce has not been issued and the recommendations are not known at this time (as of the printing of this document). After the report and corresponding recommendations are known, this request will be reevaluated.

BUDGET AUGMENTATION REQUESTS RECOMMENDED

Unit Amount	Description	Results
Gross: $100,000 General Fund Support: -$130,000	1.0 Public Health Microbiologist I/II at the Public Health Laboratory Requested in order to meet demand for laboratory testing.	Meet demand for testing services. 6,000 tests for sexually transmitted diseases will be performed by this position. Generate revenue of at least $230,000, which will help pay for the fixed costs associated with the laboratory and reduce the level of General Fund support by $130,000.
Gross: $22,067 General Fund Support: -$22,933	0.5 Senior Account Clerk to assist with billing at the Public Health Laboratory Volume of billings has increased 55% over the past three years and the current billing staff are unable to keep up with the volume	This position will generate an additional $45,000 of revenue by pursuing claims initially denied by third party payers. This additional revenue will help pay for the fixed costs associated with the laboratory and reduce the level of General Fund support by $22,933.

Unit Amount	Description	Results
Gross: $103,248 General Fund Support: -$30,140	1.0 Public Health Microbiologist I/II at the Public Health Laboratory. The laboratory would like to offer a new type of tuberculosis testing, QuantiFERON-TB Gold, which is currently not available in the County. This position would support the demand created by this new testing service (this test is shorter and more accurate than the traditional tuberculosis skin test).	Meet demand for testing services. A minimum of 2,568 QuantiFERON- TB Gold tests will be conducted in the first year of service. Generate revenue of at least $133,361, which will help pay for the fixed costs associated with the laboratory and reduce the level of General Fund support by $30,140.
Gross: $25,431 General Fund Support: $1,919	0.25 Public Health Nurse to support the Child Health & Disability Prevention (CHDP) program, which is a state mandated service (change from 0.75 to 1.0 FTE).	Increase provider site visits/chart audit from 7/year to 9/year. Increase provider educational programs from 1/year to 2/year reaching 67% of provider sites. Increase new/returning provider outreach with goal to secure one new dental surgery provider located in county or at a nearby county. Improve case management follow-up percentage from 60% to 70% in order to secure required treatment for an additional 100 children.
Gross: -$41,529 General Fund Support: -$52,687	1.0 Physical/Occupational Therapist II position for the state mandated California Children's Services (CCS) program. The County is mandated to provide specialized physical and occupational therapy for eligible children in public schools.	The County is mandated to provide this service and to meet caseload standards prescribed by the state. If this position were not added, the County would be required to contract for the provision of these services at an additional cost of $119,000. The addition of this position reduces expenses by $41,529 and increases revenues by $11,158 as compared to the contract option, thus saving the County General Fund $52,687. Reduce caseloads for the 5.0 staff therapists from the currently prescribed 35 treatment hours/week to 29, which brings the program in compliance with the state staffing standard of 30 hours or less.

Unit Amount	Description	Results
Gross: $47,887 General Fund Support: $5,842	1.0 Patient Services Representative for the California Children's Services program (CCS). Patient Services Representatives review patient requests, obtain medical documentation, communicate with providers and vendors, and conduct financial eligibility interviews. If this position is not added, staff will not meet mandated timelines for providing authorizations and for assisting clients and providers, which could jeopardize funding for the CCS program.	Reduce caseloads for Patient Services Representatives from 500 cases each to 334 cases each, which will bring the program in compliance with the state standard of 375 cases or less. Meet state mandated program and audit requirements.
Gross: $91,860 General Fund Support: $45,930	1.0 Environmental Health Specialist I/II in order to implement the federally mandated Storm Water Management Program.	Meet the federally mandated National Pollution Discharge Elimination System (NPDES) requirements (Storm Water Management Program).
Gross: $0 General Fund Support: $0	1.0 Environmental Health Specialist I/II in order to keep up with demand for testing services. This position is recommended to be added to the position allocation list for FY 07-08 but not funded or filled until FY 08-09. The reason being is that these services are revenue offset with fee revenue (charge for services). The fee schedule for FY 08-09 will be updated during the fall of 2007 in order to reflect this additional position.	Starting FY 08-09: Number of annual food safety inspections will increase from 1,475 to 2,000. Number of annual swimming pool inspections will increase from 175 to 275. Number of annual water well seal inspections will increase from 125 to 500.

BUDGET AUGMENTATION REQUESTS NOT RECOMMENDED

Unit Amount	Description	Results
Gross: $76,419 General Fund Support: $38,258	1.0 Department Automation Specialist for the Bioterrorism & Environmental Health Divisions of the Health Agency	Implement Envision Field Inspection System/Field Tablet computers Integrate Envision and Geographic Information Systems (GIS) functionality. Post Food Inspection Reports on the Public Health website. Implement Envision Connect. Maintain computer hardware and software to minimize downtime. Return functionality within 24 hours.

Unit Amount	Description	Results
Gross: $31,975 General Fund Support: $31,975	0.5 Social Worker I/II (increase from 0.5 to 1.0) for the Public Guardian program.	Client conservatorship cases contested in court will decrease from 36% to 29%. Clients' satisfaction with services provided will increase from 3% to 6% of the total caseload, benefiting overall client recovery, resulting in the termination of their conservatorship. Client visits will increase by 50% (from 2/year to 4/year). Clients' property will be secured by filing accountings within six months of appointment and annually thereafter in 100% of all conservatorship estate cases.
Gross: $59,440 General Fund Support: $48,894	1.0 Health Education Specialist to support activities associated with the Childhood Obesity Prevention Taskforce.	Three Planning Commissions will evaluate and adopt specific elements of Smart Growth principles that increase physical activity through community design. Four grants will be applied for with Public Health Department staff assistance to implement or augment physical activity/nutrition activities to reduce obesity by county or community partners. Two school districts will adopt additional activities through their wellness policies to increase physical activity, improve nutrition. Plans will have been prepared and commitment received from a minimum of five schools in the County to have at least 1,250 students involved in Walk to School Day in October 2008.

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.

02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Actual Results	06-07 Adopted	06-07 Projected Results	07-08 Target
0.8	1.1	0.7	0.4	1.0	1.0	1.0

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."

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.

How are we doing? There was one reported foodborne disease outbreak in fiscal year 2005-06; translating to a rate of 0.4 per 100,000 population. So far in 2006-07, no outbreaks have been reported. However, as outbreak(s) may still occur, the projected result for 2006-07 remains at a rate of 1.0 per 100,000 population. Benchmark data from other counties are not available.

2. Performance Measure: Cost per visit for childhood immunization.

02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Actual Results	06-07 Adopted	06-07 Projected Results	07-08 Target
$ 44.00/ visit	$ 56.38/visit	$ 29.73/ visit	$38.24/ visit	$ 41.00/ visit	$ 48.00/visit	$50.00/visit

What: Measures the cost to the County 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.

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.

How are we doing? In the first six months of 2006-07, there were 1,081 child visits with an average net county cost per visit of $46.31. The average total expenses per child visit were $62.33, and the average revenue per visit was $16.02.

Net county cost reflects gross costs ($62.33) minus revenue from fees for services ($16.02). The state mandates that childhood immunizations are provided regardless of a client's ability or inability to pay. When the client can pay, the Department charges $25/visit. Through the state's Vaccines for Children program, vaccines are provided free of cost. Overall, net county costs will increase as personnel costs increase, i.e. annual COLA's. The average cost per visit for childhood immunization in 2005-06 was $38.24. The number of children immunized in this period last year is similar to this year. Benchmark data from other counties are not available.

3. Performance Measure: Percentage of low birth-weight infants.

02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Actual Results	06-07 Adopted	06-07 Projected Results	07-08 Target
5.1%	5.5%	5.5%	*5.9%	5.9%	6.5%	6.8%

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.

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.

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; continuing an increasing trend in the county and statewide. Results from recent birth records (AVSS) indicate that our result for 2006-07 will be 6.5%, and the state will be 6.9%. Analysis of local data indicates that low birth weight infants are more frequently born to women in the 35-39 year age group, to women of Asian ethnicity, to women who are mutliparous (4+ deliveries), and to women who receive late or unknown prenatal care. Several programs are working to reduce the rate of low birth weight, such as First Time Mothers, Teenage Pregnancy Prevention (TAP), Tobacco Cessation and Prevention of Peri-natal Substance Use. Emphasis is being placed on increasing outreach, education and referral to high-risk women and increasing accessibility to early pre-natal care through the Community Health Centers.

Per the 2006 County Health Status Profiles (based upon 2002-2004 data), our county's 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).

* 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).

4. Performance Measure: Percentage of live born infants whose mothers received prenatal care in the first trimester.

02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Actual Results	06-07 Adopted	06-07 Projected Results	07-08 Target
82.9%	81%	82.4%	*82.7%	85%	83.1%	84.6%

What: Percentage of live born infants, born to county residents, whose mothers received prenatal care in the first trimester of pregnancy.

Why: Early, high quality prenatal care reduces the incidence of morbidity and mortality for both mother and infant.

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%. Results from recent birth records indicate that our result for 2006-07 will be 83.1%, and the state will be 85.8%. SLO County has 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 prenatal care 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).

Benchmark data in 2005-06 was: California, 86.4%, Santa Cruz – 90.7%, Ventura – 90.1%, Placer – 89.8%, Kern – 83.9%, Monterey – 83.7%, Santa Barbara – 82.0%, and Napa – 80.3%.

* 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.

02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Actual Results	06-07 Adopted	06-07 Projected Results	07-08 Target
13.4	13.0	10.6	11.5	11.0	10.6	10.5

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. Preliminary data for 2006 indicate that the projected results for 2006-07 will be approximately 10.6/1000 population. 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.

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.

*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.

02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Actual Results	06-07 Adopted	06-07 Projected Results	07-08 Target
97.2%	97%	97.3%	97.8%	98%	97%	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 the first quarter of fiscal year 2006-07 was 4,329; or 96.2% of the eligible caseload. This coverage rate is lower than the adopted target for this year and is reflective of an approximately 15% shortage of direct service staff during the first quarter of FY 06-07. Although staff vacancies are anticipated to be filled by the end of second quarter, it will be difficult to catch-up up the participation shortfalls experienced in the first and possibly the second quarters of FY 06-07. Projected results of FY 06-07 are anticipated to be at 97%, which is within the state mandated range of 97-100% participation.

Participation for same time period in the benchmark counties was: Marin - 2,726 (102.9%); Monterey - 20,089 (97.9%); Napa - 3,733 (100.2%); Santa Barbara - 16,025 (99.1%); Santa Cruz – 8,254 (102.9%); Placer – 3,379 (105.6%); Statewide - 1,360,261 (97.5%).
A county can have a percentage greater than 100% when the county's actual eligibility is higher than the CA State WIC Branch's allocated caseload. Allocated caseloads, which serve as a target, are based upon population and poverty estimates for different regions of California and may not always reflect the current local situation.

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

02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Actual Results	06-07 Adopted	06-07 Projected Results	07-08 Target
3.2	2.1	2.7	4.6	3.2	3.2	7.0* New measure; not comparable

What: Measures the number of positive Human Immunodeficiency Virus (HIV) antibody tests as a rate per 100,000 population. Specimen are processed in the Public Health Lab from samples 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 high-risk people to test.

How are we doing? In the first quarter of 2006-07, there has been one HIV positive antibody test, which is less than the number reported in the same period last year. During fiscal year 2005-06, there were 12 HIV positive antibody tests for a rate of 4.6 /100,000. The program is on track to reach the adopted year-end target.

The program conducts outreach efforts to encourage high-risk individuals to get tested, including use of a 20-minute rapid oral test to provide faster results. 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. Comparable benchmark data from other counties are not available.

* The performance measure is expected to change for 2007-08 to reflect the 'number of new HIV cases'. Since HIV is now a mandatory reportable condition (previously only AIDS was reportable), the new target is the estimated total number of new HIV/AIDS cases identified in the County by all providers. The target is based on statewide and local HIV and AIDS data.

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

02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Actual Results	06-07 Adopted	06-07 Projected Results	07-08 Target
*22%	**19%	**19%	***20%	17%	20%	19%

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? According to the CA Healthy Kid Survey 2005, 20% of 11th graders smoked cigarettes in the past 30 days. This result is slightly higher than the 19% of 11th graders reported in 2003-04 and 2004-05, which were based on the Healthy Kids Survey 2003. Because the data is reported in surveys done bi-annually, our projected results for 2006-07 will reflect the same percentage of 20% as in 2005-06.

In 2005, 10% of 11th graders smoked in Monterey County, 15% in Kern, and 18% in Napa; data from the other benchmark counties is not yet available. The most recent California Student Tobacco Survey data, 2005-06, for 11th graders showed a statewide percentage of 15.2%; a slight increase from 14.8% in 2003-04. The national Youth Risk Behavior Survey – among 9-12th graders - results were 23% in 2005, a decrease from 24% in 2004.

* The FY 2002-03 actual results are from the Healthy Kids 2001 survey.
** The FY 2003-05 and 2004-05 Actual Results are from the Healthy Kids 2003 survey.
*** The FY 2005-06 results updated to include results from the Healthy Kids 2005 survey.

9. Performance Measure: Adult smoking rates.

02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Actual Results	06-07 Adopted	06-07 Projected Results	07-08 Target
*13.4%	*13.4%	**16.0%	Biannual Survey	15.5%	Biannual Survey	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? Release of results from of the 2005 California Health Interview Survey (CHIS) have been delayed and are now expected in January 2007. The results reported in 2004-05; 16% of adult smoke cigarettes, are from the 2003 California Health Interview Survey (CHIS). Due to on-going programming, we expect to be on track to reach our adopted target for 2006-07.

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. According to CDC's Behavioral Risk Factor Surveillance System for 2005, the current smoking rate in CA is 15.2% and in the US is 20.6%.

* 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.

02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Actual Results	06-07 Adopted	06-07 Projected Results	07-08 Target
95.2%	95.3%	95.3%	95.8%	96.0%	96.0%	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, 95.8% of the routine water samples were in compliance with the drinking water standards. The compliance rates have improved slightly each year since 2001-02. In the first quarter of 2006-07, 93.6% of the samples have been in compliance. Year-end compliance rates are expected to be in line with the adopted target for 2006-07. 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

02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Actual Results	06-07 Adopted	06-07 Projected Results	07-08 Target
HF - 3,833 HK - N/A	HF - 3,824 HK - N/A	HF - 4,331 HK - N/A	HF - 4,436 HK - 557	HF - 5,000 HK - 750	HF - 4,600 HK - 625	HF - 4,800 HK - 675

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 preventive 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 (HF)* as of October 2006 was 4,531. During the 4-month period of July-October 2006, there were 561 newly subscribed children and 526 children who dis-enrolled in the Healthy Families Program. The projected result for 2006-07 was based on an anticipated increase rate of 10%, which is not holding true. In line with current program expansion rates and decreased staff time (outreach efforts were reduced 25% due to reduced funding), the projected result for 2006-07 will be approximately 4,600 children covered.

Healthy Families Program, funded through Federal (SCHIP) and State funds, has no enrollment cap. It is reliant on the local outreach efforts of public health, schools, family advocates, Department of Social Services and the Children's Health Initiative to provide families the opportunity to enroll their children. Estimating the number of children eligible for the program is difficult due to fluctuating family economic status, particularly in young families as they more apt to move or change family size thus changing eligibility status. 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).

According to 2006 statewide data, 64.7% of dis-enrollments in the past 12 months were due to 'possibly avoidable' reasons (such as, enrollment information incomplete or not received, payment not received) and 35.3% 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, anecdotally, 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 October 2006 was: Napa – 2,604, Placer – 3,521, Santa Cruz – 5,022, Santa Barbara – 8,755, Monterey – 16,513, Marin – 2,612. 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 (HK) in September 2005. This program is funded through private and public grants and local fundraising efforts, and as such is limited in the number of children it can cover by its budget. As of October 1, 2006, 581 children had been enrolled and 447 were on the waiting list pending further program funding. Of those children enrolled, 177 are age 0-5 years and 404 are age 6-18 years. Within the 6-18 year old age group, 76 were originally enrolled in the 0-5 year age group. Furthermore, 25 children had dis-enrolled from the program.

The adopted target for 2006-07 was incorrectly reported at 750 children. According to program documents the 2006-07 target should have been 600 children. The program expects to cover 625 children by year end and is well on track towards its annual target. Of the benchmark counties, Santa Cruz, Santa Barbara and Napa have expansion programs for children's health insurance, yet enrollment data is not readily available.

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.

02-03 Actual Results	03-04 Actual Results	04-05 Actual Results	05-06 Actual Results	06-07 Adopted	06-07 Projected Results	07-08 Target
80.2%	73.1%	63.8%*	49.4%	75%	65%	65%

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), 26% were on the wait list for services, and 24% refused services or could not be located. So far, in the first quarter of 2006-07, 37 women have been referred. Of these women, 62.2% have been enrolled, 24% are on the wait list, and 13.5% have moved or refused services.

Considering staffing levels, the 2006-07 adopted target is ambitious. The program expects to maintain current coverage levels for an projected year-end result of 65%. In the last couple of years, PHNCMS has lost 2 FTE field nursing staff due to budget cuts and has a 0.75 FTE 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.

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.

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