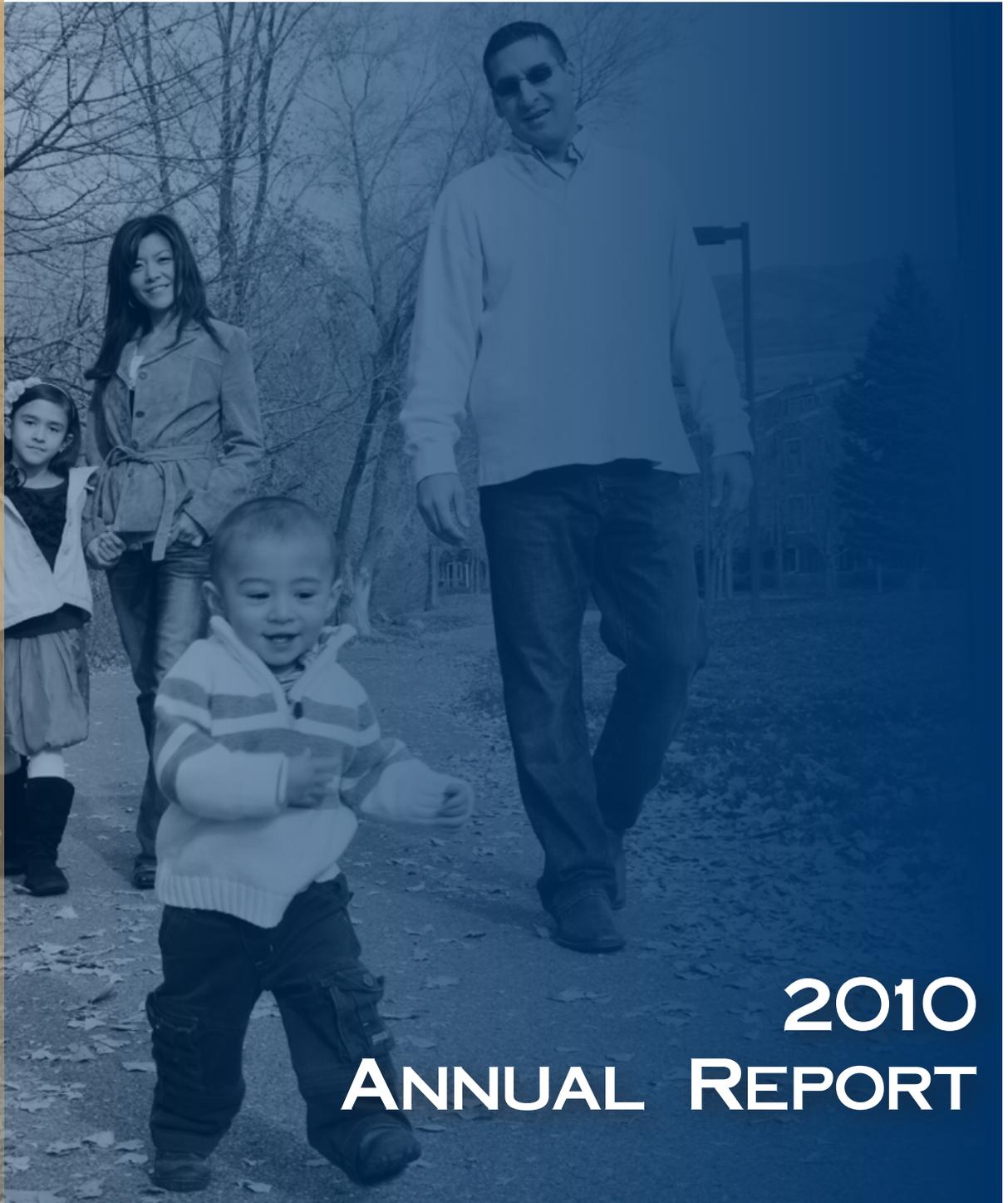




South Central Public Health District

Prevent. Promote. Protect.



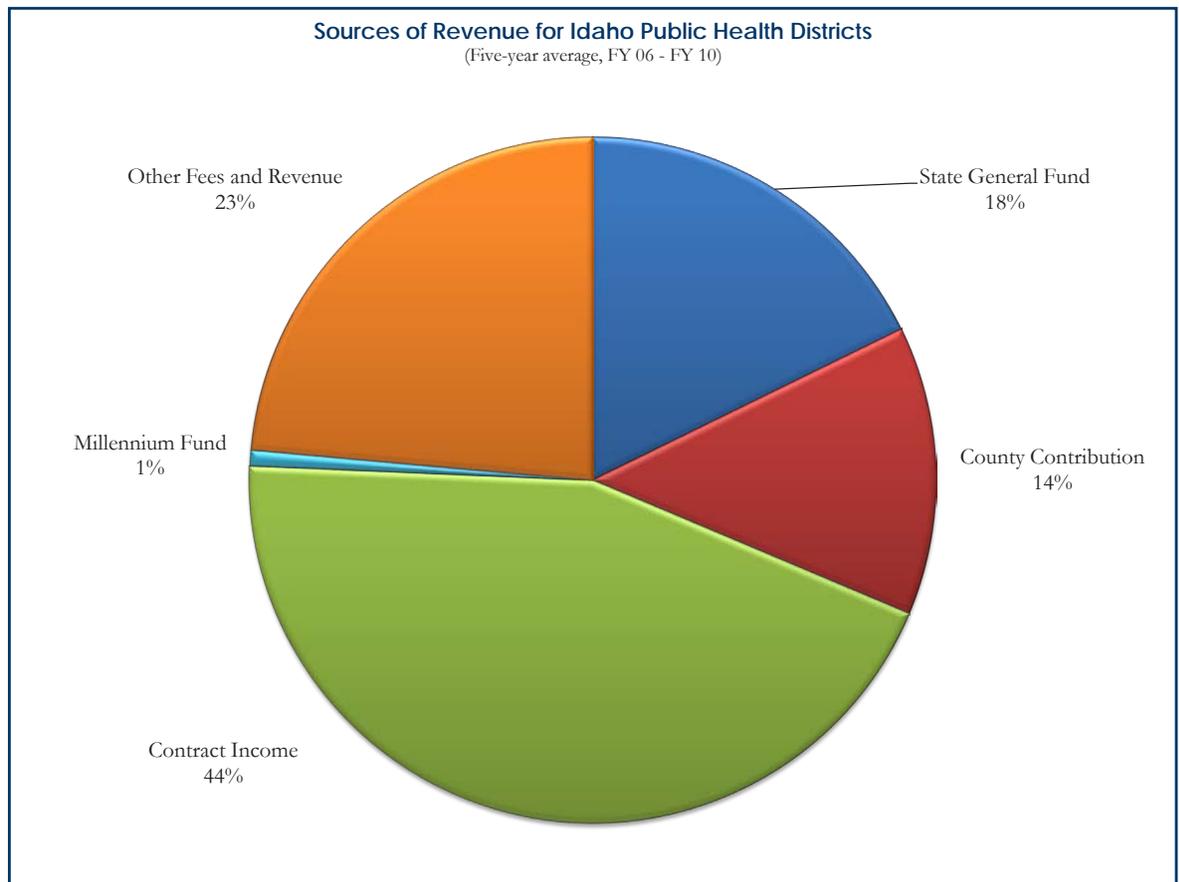
**2010
ANNUAL REPORT**

Serving communities in Blaine, Camas, Cassia, Gooding,
Jerome, Lincoln, Minidoka, and Twin Falls Counties



Difficult economic conditions continue to face the State of Idaho. Recognizing that, Idaho Public Health Districts have eliminated 13.9 positions over the last fiscal year (FY). Over the last four years, the Districts have reduced 122 positions for a reduction in staff of 16.5%. Personnel costs make up 75% of the total budget for the Districts. Large increases for the employer share for medical benefits are very concerning. Most of the projected increases for FY 2012 are personnel cost related, but general and medical supply inflationary costs are significant as well. Projected cost increases force a 2.32% General Fund increase from the base budget. Over the last five years, revenue receipts have averaged an annual growth rate of -0.79%. Projected cost increases for FY 2012 follow:

Employee Compensation @ 1%	\$314,400
Employee Benefit Increase and end of Health Ins. Holiday	\$1,584,200
General Inflation (including medical supplies)	\$168,600
Total:	\$2,067,200



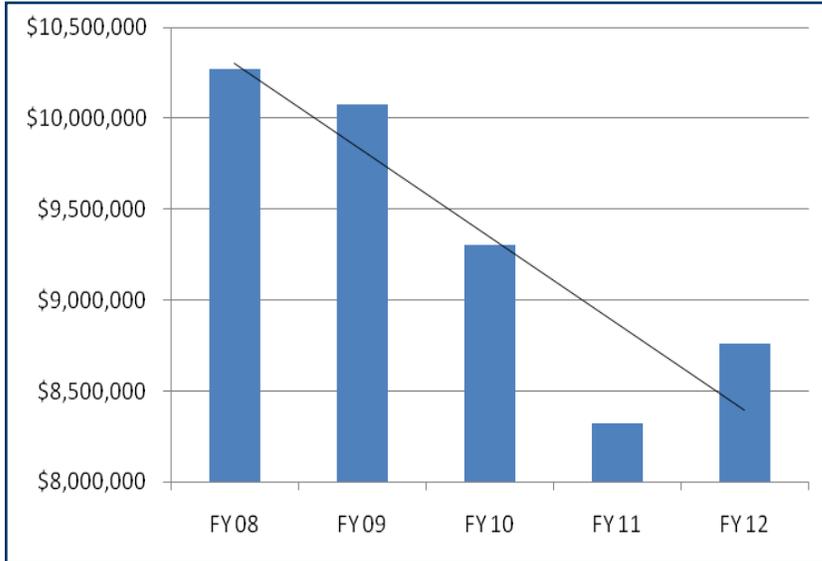
Over the last five year period, the Idaho Public Health Districts received an average of 32% of their funding from the counties and State General Fund. Contracts originating primarily at the federal level account for 44% of the funding, and user fees and other revenue amount to 23%.





Funding Trend Issue

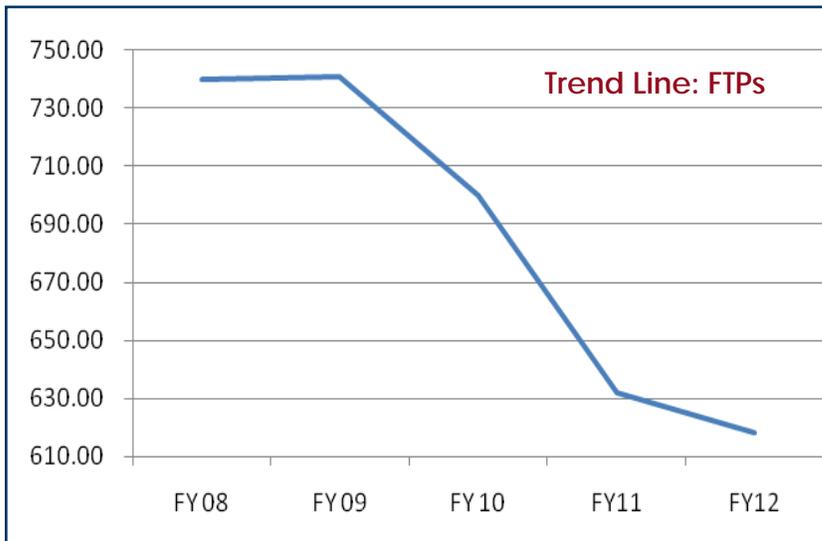
The funding from State Tax revenues continues to drop for Idaho Public Health Districts. This trend is common to all state funded entities in the past few years with FY 2010 and 2011 being the hardest years so far. The reductions are largely dealt with by cuts in staff. Idaho Public Health Districts must be able to retain the infrastructure needed to respond as needed to issues such as the H1N1 pandemic flu outbreak.



FY 08, 09, and 10 amounts are actual State General Funds received by Idaho Public Health Districts; FY 11 is the original appropriation amount, and FY 12 is the submitted request amount.

Full Time Equivalent Positions Have Declined

Over the three years FY 08 to FY 10, plus FY 11 and FY 12 projections, full time equivalent positions (FTP) have declined by 121.56. That is an average decline of over 30 positions per year.





Subsurface Disposal Rules - IDEQ and IPHD Action Plan

During the 2010 Legislative Session, key legislators and the Environmental Common Sense Task Force (ECSTF) met to discuss potential delivery improvements for the statewide subsurface sewage disposal program. As a result, the Idaho Department of Environmental Quality (IDEQ) and the Idaho Public Health Districts (IPHD) met, on multiple occasions throughout the year, to address the concerns and issues from the legislature. The result was the development and implementation of a joint Action Plan.

In March 2010, the ECSTF identified four key elements: 1) Consistent application of the statewide Rules and Technical Guidance Manual (TGM); 2) Review of individual district policies; 3) Review of district rules; and 4) Review of permit appeal processes. All tasks were required to be addressed and improvements put into action prior to commencement of the next legislative session (January 2011).

The following tasks have been completed and vetted between agencies:

IPHD:

1. Standardized forms (Element 1) completed May 1, 2010
2. Standardized Operations Manual (Element 1) completed October 1, 2010
3. Peer Review (Element 1) completed October 1, 2010
4. Standardized fee categories (Element 2) completed July 1, 2010
5. Idaho Association of District Boards of Health (IADBH) review of District Appeal Process (Element 4) June 18, 2010*

IDEQ:

1. District Staff Training (Element 1) conducted August, September, and October 2010
2. Review of District Policies (Element 2) May 26, 2010**
3. Review of District Rules (Element 3) May 26, 2010**

* IADBH agreed to not charge any fees associated with the appeal process. Procedures have been updated through the Standard Operating Procedures (SOP) manual and posted to district websites (if applicable).

**Those district policies found to be inconsistent with the intent of IDEQ IDAPA Rules or chapter 52, title 67, Idaho Code, were rescinded by the respective district's Board of Health. Any district promulgated IDAPA Rule will be adjusted through the legislative process.

The Idaho Public Health Districts value our commitment to preventing, promoting, and protecting the public's health in Idaho. We are dedicated to providing a consistent statewide implementation of the subsurface disposal program (as delegated by IDEQ) and in providing for the lawful and safe development of water and sewage facilities.





Updating Idaho's Immunization Rules

Since the start of the National Immunization Survey in 1994, Idaho has almost always ranked as one of the lowest states in the country for childhood immunization rates. Updating state immunization requirements is a proven method to increase the number of children who are fully immunized.

The Idaho Department of Health and Welfare is proposing to make changes to the school and childcare immunization rules to more closely align Idaho with the national immunization recommendations. As an example of why this is needed, Idaho is one of only three states that does not require varicella vaccine prior to school entry. Before the vaccine was available in the United States, about 11,000 people were hospitalized for chickenpox each year, and approximately 100 people died from the disease.

The proposed changes add the following vaccines for admission to public, private, or parochial schools: fourth dose of polio, two doses of hepatitis A, and two doses of varicella. In addition, children entering seventh grade will be required to have one booster dose of tetanus, diphtheria, pertussis (Tdap) vaccine and one dose of meningococcal vaccine. Children attending childcare will be required to have the following age appropriate additional vaccines: hepatitis A, varicella, pneumococcal, and rotavirus.

The 53 member Idaho Association of Local Boards of Health supports these changes. While the proposed rules raise the public health standard, parents and guardians still retain the right not to immunize their children by simply signing an exemption statement. In fact, Idaho law requires that before an immunization is administered to any child, the parent or guardian of the child shall be notified that immunizations are not mandatory and may be refused on religious or other grounds. It is also important to note that the new vaccines required by the proposed rules are free to children living in Idaho. An administration fee can be charged for the vaccine, but many health care providers and all seven Idaho Public Health Districts will reduce or waive the administration fee if the parent or guardian does not have the ability to pay.

Immunizations are a safe and effective means for eradicating preventable diseases, yet thousands of children continue to develop vaccine preventable diseases due to inadequate immunizations. The proposed rules will make a difference in keeping Idaho's children healthy and safe.





Tobacco Tax Increase Proposal

In June 2010, the Idaho Association of District Boards of Health collectively approved a resolution to support a tobacco tax increase in the State of Idaho. Their position in the resolution is “To support an increase in the tobacco tax to enhance comprehensive tobacco prevention and control efforts to reduce youth and adult tobacco use rates and decrease the tax burden derived from tobacco-attributable expenditures.”

Tobacco use is well known to be the leading cause of preventable disease and death in the United States and Idaho. Annually, 1,500 Idahoans die from tobacco-attributable diseases. Tobacco-caused illnesses cost the state more than \$319 million per year, including \$83 million in expenditures for Medicaid alone.

Idaho’s cigarette tax at \$0.57 per pack is lower than all of the surrounding states (WA @ \$3.025; MT @ \$1.70; UT @ \$1.70; OR @ \$1.18; NV @ \$0.80, WY @ \$0.60). The average rate in the nation is \$1.45. Idaho is ranked 42nd in the nation, meaning 41 other states have higher rates of tax on cigarettes. Idaho is right in there with many of the tobacco producing states, such as Virginia, West Virginia, North Carolina, South Carolina, and Georgia.

Idaho Public Health Districts are supporting the tobacco tax resolution through a coalition of associations throughout the state, led by the American Cancer Society, Cancer Action Network (ACS CAN). The ACS CAN proposed \$1.25 increase per pack of cigarettes would raise an additional \$48.2 million dollars a year in revenue and a \$2.9 million dollar per year increase in revenue for other tobacco products. The ACS CAN facts note that residents’ state and federal tax burden from smoking-caused government expenditures is \$539 per every tax paying household.





NEW REVENUES, PUBLIC HEALTH BENEFITS & COST SAVINGS FROM A \$1.25 CIGARETTE TAX INCREASE IN IDAHO

Current state cigarette tax: 57 cents per pack (42nd among all states)
Smoking-caused costs in Idaho: \$7.85 per pack

Annual healthcare expenditures in Idaho directly caused by tobacco use: \$319 million
Smoking-caused state Medicaid program spending each year: \$83.0 million

New Annual Revenue from Increasing the Cigarette Tax Rate by \$1.25 Per Pack: \$48.2 million

Additional Revenue from Raising Other Tobacco Product Rates to Parallel New Levels: \$2.9 million

New Annual Revenue is the amount of additional new revenue over the first full year after the effective date. The state will collect less new revenue if it fails to apply the rate increase to all cigarettes and other tobacco products held in wholesaler and retailer inventories on the effective date.

<u>Projected Public Health Benefits from the Cigarette Tax Rate Increase</u>	
<i>Percent decrease in youth smoking:</i>	19.0%
<i>Kids in Idaho kept from becoming addicted adult smokers:</i>	12,500
<i>Current adult smokers in the state who would quit:</i>	7,800
<i>Smoking-affected births avoided over next five years:</i>	2,050
<i>Idaho residents saved from premature smoking-caused death:</i>	6,000
<i>5-year health savings from fewer smoking-affected pregnancies & births:</i>	\$3.5 million
<i>5-year health savings from fewer smoking-caused heart attacks & strokes:</i>	\$3.3 million
<i>Long-term health savings in the state from adult & youth smoking declines:</i>	\$292.9 million

- Tax increases of less than roughly 25 cents per pack or 10% of the average state pack price do not produce significant public health benefits or cost savings because the cigarette companies can easily offset the beneficial impact of such small increases with temporary price cuts, coupons, and other promotional discounting. Splitting a tax rate increase into separate, smaller increases in successive years will similarly diminish or eliminate the public health benefits and related cost savings (as well as reduce the amount of new revenues).
- Raising state tax rates on other tobacco products (OTPs) to parallel the increased cigarette tax rate will bring the state more revenues, public health benefits, and cost savings (and promote tax equity). With unequal rates, the state loses revenue each time a cigarette smoker switches to cigars, RYO, or smokeless. To parallel the new \$1.82 per pack cigarette tax, the state's new OTP tax rate should be at least 60% of wholesale price with minimum tax rates for each major OTP category linked to the state cigarette tax rate on a per-package or per-dose basis.

Needed State Efforts to Protect State Tobacco Tax Revenues

Having each of the following measures in place will maintain and increase state tobacco tax revenues by closing loopholes, blocking contraband trafficking, and preventing tax evasion.

State tax rate on RYO cigarettes equals the state tax rate on regular cigarettes	Yes
State tax rates on other tobacco products match the state cigarette tax rate	Yes
State definitions of "cigarette" block cigarettes from wrongfully qualifying as "cigars"	No
State definitions of "tobacco product" reach all tobacco products	No
Loopholes for the new generation of smokeless products (snus, tablets, etc.) closed	No
Minimum taxes on all tobacco products to block tax evasion and promote tax equity	No
"High-tech" tax stamps to stop counterfeiting and other smuggling and tax evasion	No
Retailers lose license if convicted of contraband trafficking	Yes
Street sales and mobile sales of cigarettes and other tobacco products prohibited	No
Non-Tobacco nicotine products without FDA approval banned	No

More information available at <http://tobaccofreekids.org/research/factsheets/index.php?CategoryID=18>

Campaign for Tobacco-Free Kids 10.07.10 / Ann Boonn & Eric Lindblom, November 4, 2010



Behavioral Health Transformation

Idaho hired the Western Interstate Commission for Higher Education (WICHE) to evaluate the Idaho Behavioral Health System. The WICHE report published in 2008 indicated that the current system is most fragmented at the community level. A primary recommendation of their report is to “Create a regionally operated, integrated mental health and substance abuse authority—or district—in each of the existing seven regions to plan, administer, and manage and/or deliver services for children and adults.” The public health model was suggested as a possible model for the regionalization.

Executive Order No. 2009-04 tasked a Behavioral Transformation Work Group (BHTWG) with “developing a plan for a coordinated, efficient state behavioral health infrastructure with clear responsibilities, leadership authority, and action.” Throughout the many meetings of the BHTWG, the public health model was a topic of discussion. The BHTWG completed their work in October 2010 with a final report submitted to Governor Otter.

Mental health and substance abuse are not part of the core services provided by Idaho Public Health Districts. Our mission is to prevent disease, disability, and premature death; promote healthy lifestyles; and protect the health and quality of the environment. With limited resources, it is difficult to consider entering into the realm of behavioral health and substance abuse services using the public health model as it exists today.

Idaho Public Health Districts provided feedback to the BHTWG Chairman that the selection of the “Transformation Champion” would appear to be critical to transformation success. This person, we believe, should be outside the state department agency structure, yet have the expertise and ability to pull stakeholder entities together with the full support of the three branches of State government.



Interesting Times

By David Fleming, Hilary Karasz, and Kirsten Wyses



David Fleming, Hilary Karasz, and Kirsten Wyses
Photo courtesy Sharon Bogan.

“A crisis is an opportunity riding the dangerous wind.”

– Chinese Proverb

One of the few things we seem to be able to agree about in our country these days is that we are still suffering through the worst economic recession in decades. And, as most of us in public health practice can attest, a consequence has been several very tough years of intense downward pressure on agency budgets with seemingly more in store for the foreseeable future. Across the country, public health workers are being laid off and public health programs are being dismantled. While many policy makers still speak to the power of prevention, when push comes to shove, budget actions to back this talk are increasingly rare.

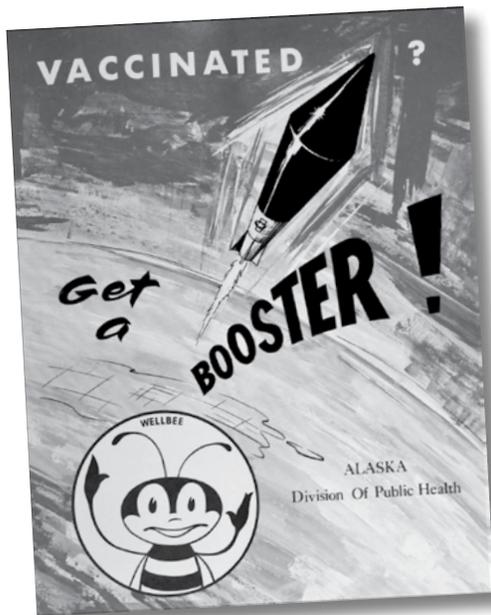
For those of us in the choir of the church of public health, these actions seem both unwise and unfair. After all, there’s plenty of money for health. Health care spending now consumes 17 cents of every dollar that passes hands in this country. And public health activities are the ones with the best track record in creating health. Most of the 30 year average increase in life span we’ve enjoyed over the past 100 years is from public health programs like immunization, improved sanitation, and public health services for young mothers. Infant mortality rates are down fifteenfold, tuberculosis is an oddity, and death and illness from childhood infectious diseases have become so rare that the nature of pediatrics has been transformed. We cannot be too proud of these successes.

Actually we can. It doesn’t take too many steps into that larger world beyond the walls of our public health church to walk headlong into harsh reality. First—let’s face it—we’ve never been high on the budget hit parade even in good times. And second, our remarkable historical victories are putting us at increasing risk for becoming victims of our own success, as we are viewed as focusing attention and resources on issues that are no longer part of mainstream health concerns. Public attention and funding are being drawn away from public health to issues perceived as more important. After a century of protecting people’s health, few people really understand what it is we now do.

So, is it time to quit or move to a developing country where we might be more appreciated? The three of us think not, for there is still much to be done, and with crisis comes opportunity for change.

Protecting the core

First though, let’s specifically affirm what should not change—our mission. Simply put, public health must continue its core work to make sure that every member of our community has the best opportunity to live as long and as healthy as possible (in public health speak, “to create conditions in which each resident can maximize the number of healthy years he or she lives.”) We ensure this by mobilizing our many partners, judiciously using available resources, and applying scientifically proven methods to attack the leading causes of preventable death and illness.



New Technology: Then

This 1964 poster, used by Alaska to promote vaccinations, features the CDC’s symbol at that time of public health, the Wellbee. Photo courtesy CDC Public Health Image Library.

What has changed over the past century is the nature of these preventable deaths and illnesses. In 1900, the three leading causes of death in this country were: 1) pneumonia, 2) tuberculosis, and 3) diarrhea. In 2010, they are: 1) heart disease, 2) cancer, and 3) stroke. As death and disease from infectious disease and infant and maternal mortality fell and those from chronic disease rose, our jobs should have followed this same epidemiologic transition. In general, they didn't.

While we can rightfully scapegoat some of the blame to political and financial realities beyond our control, as a discipline, we have been slow to see and fully embrace our new work. Chronic disease and injury are now the leading causes of preventable death and it's time to confront them head on. Sadly, there is no shortage of work. In fact, it may well be that the current generation will be the first on record where children don't live as long as their parents.

So does this mean we should stop our communicable disease control programs and services for mothers and infants? Of course not. We absolutely need to protect these successes with ongoing, active programs. But to remain relevant in the 21st century we can and must also focus our work on where we can make the most difference within and across our portfolios. And yes, to make changes that will meaningfully reduce rates of chronic disease and injuries, we do need more money. But, to both argue the best possible case for more money to our funders and to do the job competently, we also need to look in the mirror at our credibility and core business practices.

Applying Business Practices

We need to learn to prioritize rather than spreading resources so thinly across so many issues that nothing gets done. We can't do everything; let's make sure each of our programs and activities works towards important and achievable goals. This doesn't mean we toss good programs that work just because they don't address obesity, but it does tell taxpayers that in tough times, we can be disciplined about how we choose to spend their money. Our argument for more funding can't be based on a "moving forward to the past" message.

We must make accountability central to any work we do, and demonstrate that we are committed to performance. For too long, we've just re-upped programs and activities because they're what we've always done, not because they're still the most effective ways to reduce disease. Let's get real. Our funders—taxpayers—are increasingly dubious that government can be trusted with their hard-earned money. Let's prove them wrong by supporting accreditation, and using zero-based budgeting and return-on-investment analyses. No program funds should be taken for granted and all programs should prove their worth. The process does not have to be onerous, but will send a message to our funders that every dime we're given is spent to maximum effectiveness.

Our core business models need to evolve. We can make greater use of new information technologies such as social media and mobile approaches such as text messaging to promote changes in our communities that can improve health. We need staff with information technology expertise to inform public opinion and link like-minded individuals and organizations to create political momentum.

The kinds of illnesses that are making us sick and killing us before our time do not all

We need to learn to prioritize rather than spreading resources so thinly across so many issues that nothing gets done.



New Technology: Now

We can make greater use of new information technologies such as social media and mobile approaches like text messaging to promote changes in our communities that can improve health. Photo courtesy Northwest Center for Public Health Practice.

Authors

David Fleming, MD, is the Director and Health Officer at Public Health - Seattle & King County. He previously directed the Bill & Melinda Gates Foundation's Global Health Strategies Program, was Deputy Director of the Centers for Disease Control and Prevention, and was State Epidemiologist of Oregon. Hilary Karasz, PhD, is a Public Information Officer and communications researcher, and Kirsten Wysen, MHSA, is a Policy Analyst, both at Public Health - Seattle & King County.

lend themselves to the regulatory approaches that have made confronting infectious disease so successful. And one-on-one health delivery will not be enough to get us where we need to be. We need systems, environment (including the food and built environments), and policy changes that will allow each person to make the healthy choice the easy choice.

Creating healthy communities

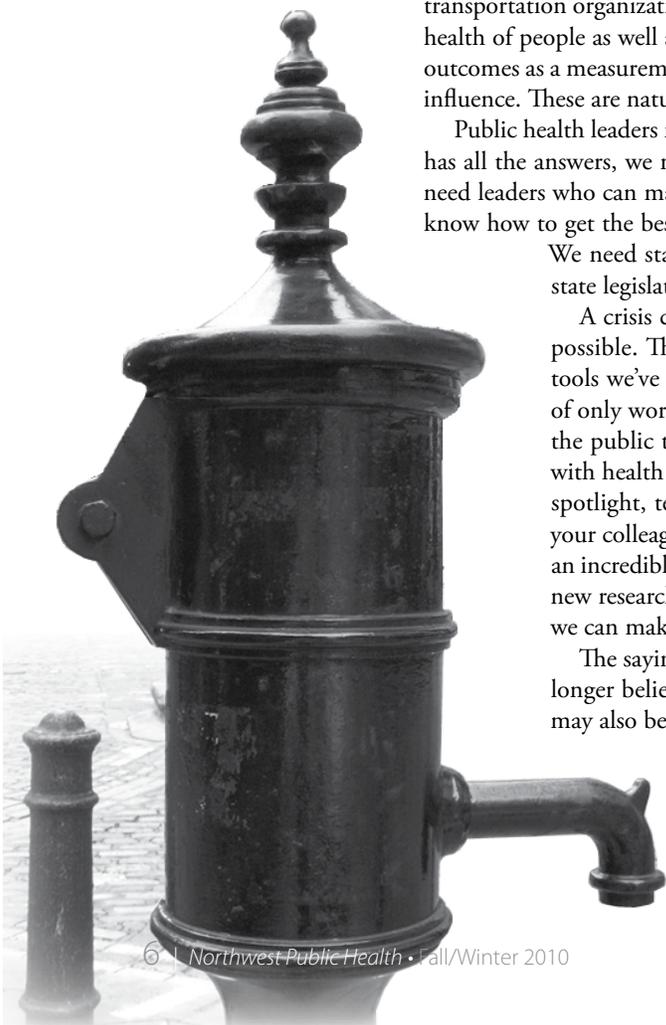
Some examples: Let's help neighborhoods provide sidewalks and safe routes to schools so that children walk rather than get fat in the family minivan. Let's make sure each neighborhood has at least as good access to healthy, nutritious, fresh food as it does to calorie-dense, low-nutrient fast food. And the evidence shows that our new, preventable causes of death do not affect the people we serve evenly. Across race, class, and neighborhoods, some people simply do not have the same opportunity to live as long and as well as others. We have created communities that do not allow making the healthy choice a practical choice. Let's make it so that not smoking is the social norm, not just in affluent neighborhoods but in every community in our region.

We need to work with and in our communities more closely, and learn how to be advocates for the health of our residents. Community development is public health work. We're extremely lucky in that people understand and value the concept of good health for all—and we need to use soft power to make our goals our community institutions' goals as well. What educator doesn't understand that healthy children are better learners, and what transportation organization doesn't agree that getting people out of cars and into mass transit is good for the health of people as well as the environment? And making the case that communities developed with health outcomes as a measurement of successful development can bring the financial community into our sphere of influence. These are natural allies who can do the work of public health, and we should ensure that they do.

Public health leaders must be up to the task. Rather than assuming that time-on-the-job means the leader has all the answers, we need leadership training and mentorship at all levels across our organizations. We need leaders who can make the tough decisions and manage a crisis but also have adaptive leadership skills, know how to get the best ideas from their employees, and are willing to try new things and test new ideas. We need staff with skills and training to develop and push policy agendas through local and state legislative bodies and change the practices of private organizations in their communities.

A crisis can create the unique window of opportunity that makes transformational changes possible. The new strategies and techniques we need now are profoundly different from the tools we've relied upon since John Snow pulled the pump handle over 100 years ago. Instead of only working for the public as their protector and provider, increasingly we must work with the public to find policies and systems changes that will get us all where we need to go. And with health care reform enacted and on the books, we have a new chance. We need to grab the spotlight, tell our story, plan our change, and move public health forward. Start talking with your colleagues and employees now about what our future looks like. Remind them that this is an incredibly exciting time to be in our profession and that health care reform, federal leadership, new research, and new partners are bringing innovative ways of thinking and working on ways we can make communities healthier.

The saying "May you live in interesting times," often cited as an ancient Chinese curse, is no longer believed to be either ancient or Chinese. Applied to today's public health landscape, it may also be time to stop thinking of it as a curse and instead as a blessing. ■

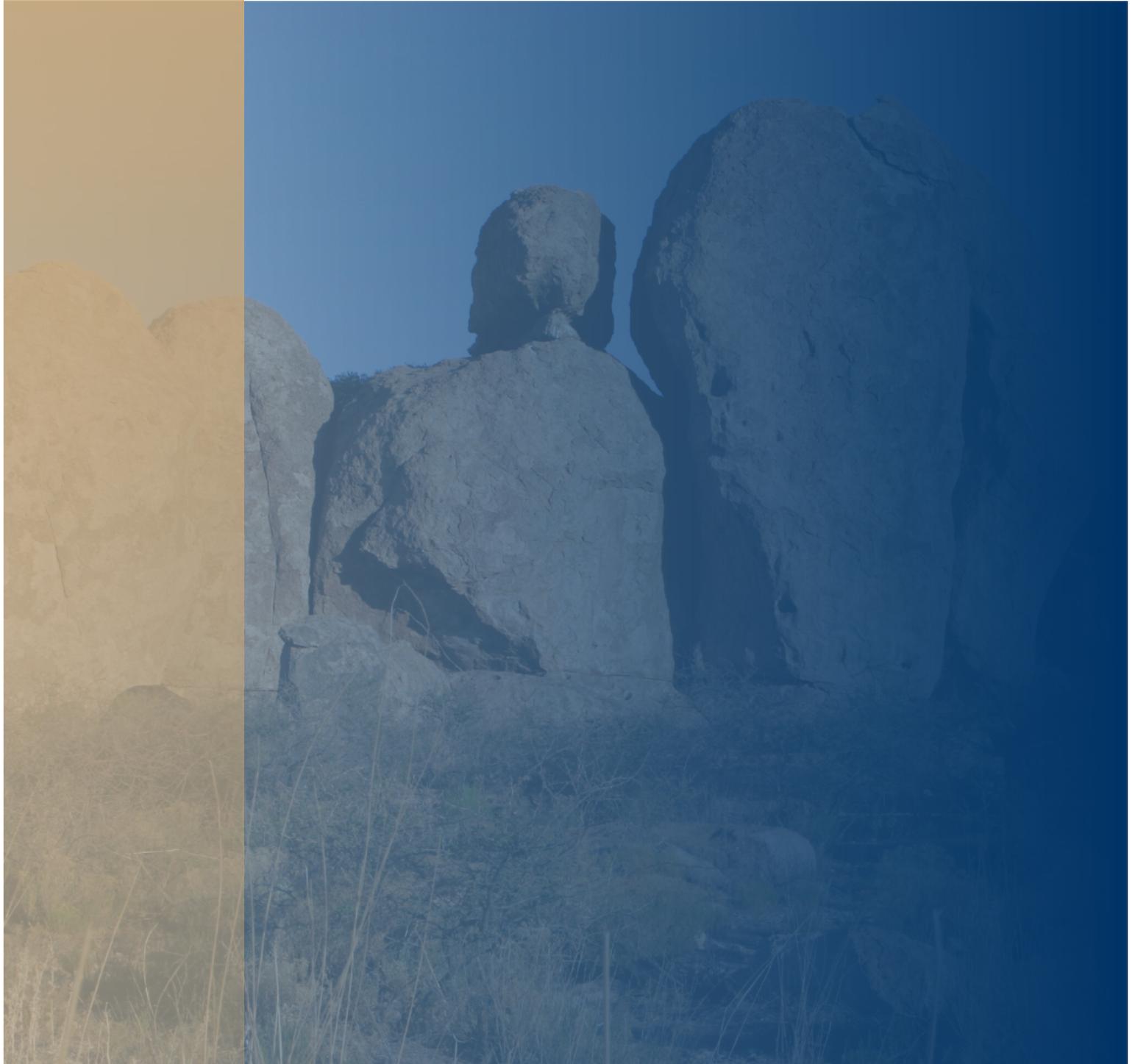


At left, John Snow's legendary pump handle missing from a replica of the water pump in London, England. Photo courtesy Kathy Hall.



South Central Public Health District

Prevent. Promote. Protect.



Budget and Division Report

PUBLIC HEALTH'S MISSION

TO PREVENT disease, disability, and premature death;
TO PROMOTE healthy lifestyles; and
TO PROTECT the health and quality of the environment.

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Terry Kramer
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Peter Curran, MD
Medical Consultant



Rene LeBlanc, MS, RS
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Bonnie Spencer, CPA
Amy Lierman
Kathlyn Egbert
Cheryle Becker, RN
Merl Egbert, REHS/RS
Karyn Goodale, MPH
Jeff Pierson, MCP

District Director
Deputy Director
Public Information Officer
Management Assistant
Family and Children's Health Division Administrator
Environmental Health Division Director
Public Health Promotion and Preparedness Programs Director
IT Resource Manager

SCPHD OFFICES



Twin Falls
(Main Office)
1020 Washington St N
Twin Falls, ID 83301
(208) 737-5900
Fax: (208) 734-9502



Jerome Office
951 East Avenue H
Jerome, ID 83338
(208) 324-8838
Fax: (208) 324-9554



Bellevue Office
117 East Ash Street
Bellevue, ID 83313
(208) 788-4335
Fax: (208) 788-0098



Rupert Office
1218 9th Street, Ste. 15
Rupert, ID 83350
(208) 436-7185
Fax: (208) 436-9066



Burley Office
2311 Park Ave., Unit 4, Ste. 4
Burley, ID 83318
(208) 678-8221
Fax: (208) 678-7465



Shoshone Clinic
Christ Episcopal Church
104 West B Street
Shoshone, ID 83352
(208) 934-4477

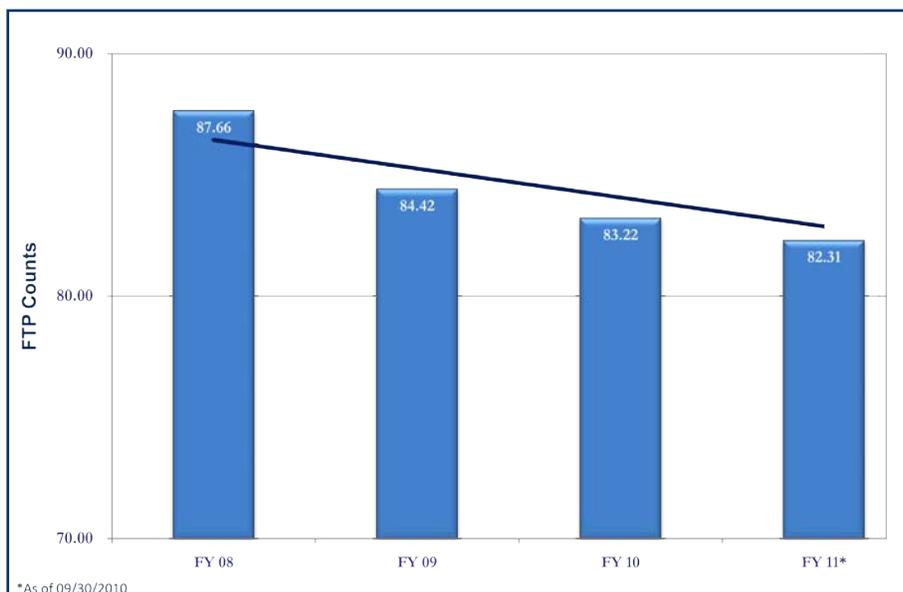


Gooding Office
255 North Canyon Drive
Gooding, ID 83330
(208) 934-4477
Fax: (208) 934-8558

South Central Public Health District (SCPHD) FY 2009 - 2011 Budget Comparison

	APPROVED FY 2009 BUDGET	APPROVED FY 2010 BUDGET	APPROVED FY 2011 BUDGET	CHANGE FY 09-11 BUDGET
ESTIMATED EXPENDITURES				
Personnel costs	\$5,050,024	\$4,821,895	\$4,724,831	(\$325,193)
Operating expenses	1,248,922	1,414,614	1,427,607	178,685
Sub-grantee payments	223,000	180,000	175,000	(48,000)
Capital Outlay—General	63,800	40,000	42,000	(21,800)
Capital Outlay--Building	-	580,000	-	-
TOTAL ESTIMATED EXPENDITURES	\$6,585,746	\$7,036,509	\$6,369,438	(\$216,308)
ESTIMATED INCOME				
County funds	\$1,011,668	\$1,011,668	\$1,011,668	-
State General Fund	1,419,600	1,214,500	1,082,976	(\$336,624)
State Millennium Fund	66,000	35,000	65,000	(1,000)
Contracts	2,785,344	3,008,321	3,133,769	348,425
Fees/donations and miscellaneous	1,303,135	1,110,020	1,076,025	(227,110)
Reserve draw	-	657,000	-	-
TOTAL ESTIMATED INCOME	\$6,585,746	\$7,036,509	\$6,369,438	(\$216,308)

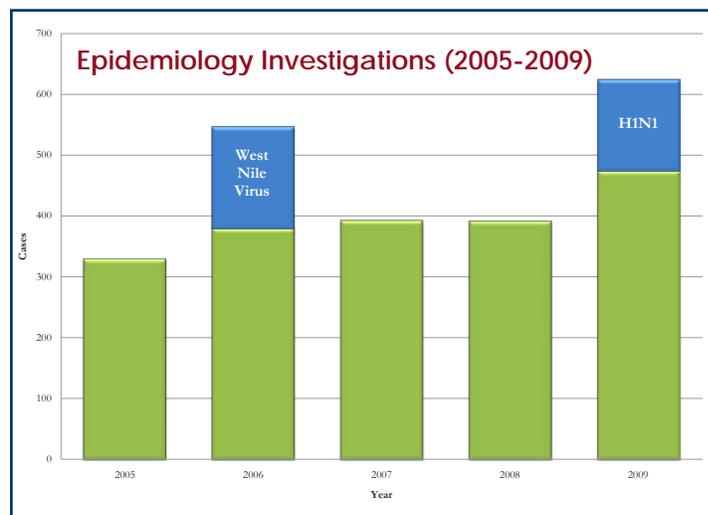
SCPHD: Personnel Staffing



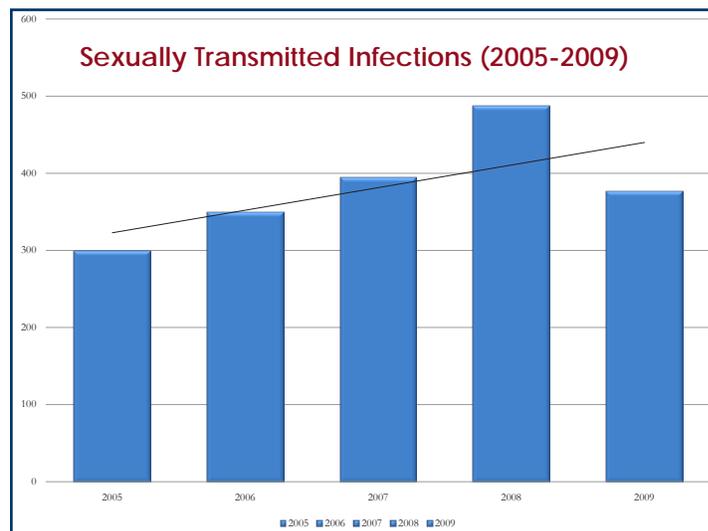
FAMILY AND CHILDREN'S HEALTH

Epidemiology

Currently, 74 diseases and conditions are reportable to the Office of Epidemiology and Food Protection at the Idaho Department of Health and Welfare or to one of the seven Idaho Public Health Districts. Of these diseases or conditions, cancer and five genetic conditions do not require response by the Idaho Public Health Districts. Non-sexually transmitted infections have seen a slow steady increase over the last five years. During 2006 and 2009, outbreaks of a single infection required massive response by the epidemiology staff as well as most of the South Central Public Health District (SCPHD) employees. SCPHD has developed an epidemiology plan to respond to outbreaks of any size. Training involves nursing as well as environmental health staff to ensure staff are ready and able to respond to outbreaks involving agencies such as schools, daycares, or entire communities.

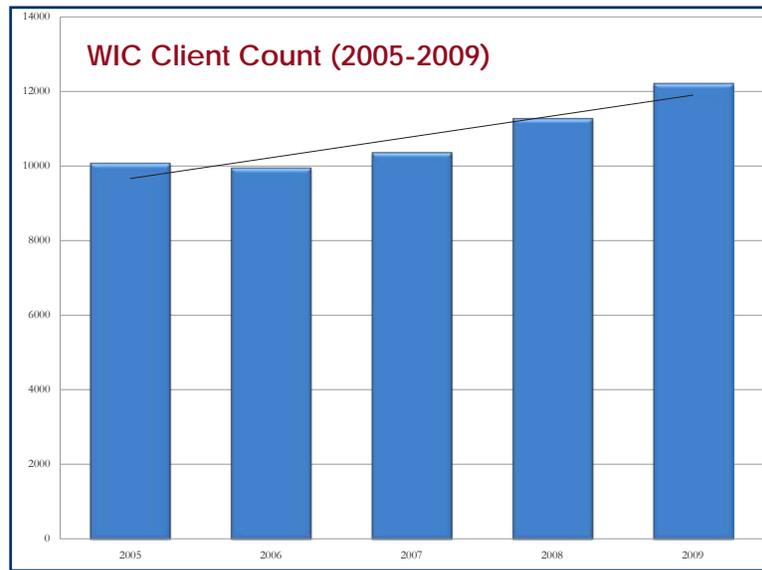


Sexually transmitted infections include chlamydia, gonorrhea, and HIV/AIDS. The number of infections in SCPHD fell in 2009, mirroring the statewide decline of 10%. Reasons for this decrease are not clear. The total number of reportable diseases for 2009 was 1,002. This translates to almost four reports per working day.



Women, Infants, and Children (WIC)

SCPHD staff provide nutrition education and food vouchers for pregnant women, breastfeeding women, and children through four years of age. The number of clients seen in this program has increased 17% since 2005. During 2009, the value of the food packages provided was \$52/month. The food packages changed in November 2009 to include fresh fruits and vegetables. The package for infants and toddlers also includes prepared baby foods. Baby foods must be plain fruits, vegetables, or meats.



School Nursing

SCPHD nurses provide services in nine school districts. Services provided include maturation and other health-related classes, care plans for medical conditions, vision screening, scoliosis screening, and review of immunization records. During 2009, H1N1 immunization clinics were provided in all school districts in our eight-county health district.

School Nurse Contracting Schools

The following schools contract with SCPHD to provide activities such as care plans for special health needs, vision screening, maturation classes, and scoliosis screening:

- Blaine
- North Valley Academy (Gooding)
- Bliss
- Richfield
- Dietrich
- Shoshone
- Filer
- Wendell
- Jerome

Early Head Start Home Visitation

In March 2010, SCPHD began a partnership with the newly-formed Early Head Start Program. SCPHD nurses provide home visits to 80 families in the Early Head Start Program. Families are given information in areas such as the importance of prenatal care, substance abuse prevention, tobacco cessation, immunizations, proper nutrition, and referral information to programs such as WIC or family planning.



ENVIRONMENTAL HEALTH

The Environmental Health Division maintains a very unique statutory (mandated by Idaho Code such as sewage, solid waste, land development and food safety), regulatory, and educational role in our communities. Other entities see this role as a necessary public health service, but they do not want nor have the manpower to do it. Our staff are trained and credentialed sanitarians (specialist in sanitary sciences, especially food and waste water) and health inspectors in a variety of disciplines. Our purpose is to protect the public and the environment from natural and particularly anthropogenic (originating from human activity) sources of pollution. Essentially we protect people from themselves.

The major legislative rules we enforce by statute, contract, or by delegation are:

IDAPA 58.01.03 Individual Subsurface Sewage Disposal Rules

IDAPA 58.01.15 Rules for Cleaning Septic Tanks

IDAPA 58.01.08 Rules for Public Drinking Water

IDAPA 16.06.02 Child Care Licensing

IDAPA 16.06.12 Idaho Child Care Program (ICCP)

IDAPA 16.02.19 Food, Safety, and Sanitation Standards

IDAPA 16.02.14 Rules for Swimming Pools

IDAPA 58.01.06 Rules Governing Solid Waste

IC 50:13 Plats and Vacations – Release of Sanitary Restrictions

As the regulatory entity of public health, it is not uncommon to receive feedback in the form of criticism which can trigger legislative scrutiny. The criticism and feedback comes from the inherent belief that persons should be able to do whatever they choose on their own land: they do not like someone coming in and setting boundaries to their activities. What is sometimes forgotten is that some human activities can have a very detrimental effect beyond the boundaries of their land on the environment, other individuals, and society as a whole.

We have witnessed examples of this kind of legislative scrutiny the last several years in the food program, and most recently the childcare and subsurface sewage programs. What began as criticism from some individuals has resulted in changes in rules, which oft-times can be more stringent with increased regulation (i.e., childcare program) and may require increased efficiency and standardization as in the residential subsurface sewage program.

Subsurface Sewage Disposal Program

This last year several bills pertaining to the subsurface sewage program were introduced during the legislative session; some were held and a few passed. The underlying request that came to Idaho Department of Environmental Quality (IDEQ) and the seven Idaho Public Health Districts (IPHD) from the Legislative Common Sense Taskforce Committee was to standardize our regulatory processes across the state. Together, IDEQ and the IPHDs created an “Action Plan” and submitted that plan to the committee. This action plan has provided the direction to our activities for the last nine months.



Subsurface Sewage Disposal Program Action Plan

#	Action Item	Responsible Agency	Due Date	Completion Date
1	Consistent Application of the Statewide Rules and TGM			
1a	Statewide Rule Implementation	IDEQ + IPHD	May 1, 2010	IDAPA 58.01.03
1b	Standard Operating Procedures (SOP) Manual (ex. District I,V)	IPHD	October 1, 2010	October 1, 2010
1c	Peer Review	IPHD	October 1, 2010	Process is included in the SOP Manual
1d	Standardized Forms	IPHD	May 1, 2010	July 1, 2010
1e	Technical Guidance Manual	IDEQ	June 1, 2010	Ongoing
1f	Staff Training	IDEQ + IPHD	December 30, 2010	October 21, 2010
1g	Installer Training & Exams	IDEQ + IPHD	October 1, 2010	Submitted for comment November 2, 2010
1h	Program Audits	IDEQ + IPHD	November 30, 2010	Being scheduled in November
2	Individual District Policies			
2a	Policy Review	IDEQ	May 1, 2010	May 26, 2010 including DAG
2b	Fee Schedules	IPHD	September 1, 2010	October 1, 2010
3	Individual District Rules			
3a	District Rule Review (Districts I, III, IV)	IDEQ	May 1, 2010	Rescinded or pending
4	Permit Appeal Process			
4a	Appeal Rule Review	IDEQ	May 1, 2010	May 14, 2010 IDAPA 41.08.01

1a. We have been enforcing the Subsurface rules since their inception, but the request of the Legislative Common Sense Taskforce Committee is to standardize the regulatory processes of enforcement across the state as much as is possible. This broad reaching request would be impractical in any other state in the union as we are the only state with only seven independent public health bodies. The rules we enforce are IDAPA rules and not local county or city ordinances as you may find in other states.

1b. Districts I and V already had SOP manuals; these were used as basis for the development of the statewide manual. This process was completed on time after Idaho Association of District Director's and IDEQ review and approval.

1c. Within this document is a procedure for the seven districts to conduct peer reviews of each other's processes on a periodic basis.

1d. The seven EH directors reviewed all application, permitting, and inspection forms and developed a standard form to be used by all districts. These new forms were put into use July 1, 2010.

1e. The legislature has asked that the effectiveness of the Technical Guidance Committee (TGC) be reviewed and that new technology be more readily considered. The TGC is facilitated by IDEQ.

1f. IDEQ developed and initiated three statewide trainings (Nampa, Pocatello, and Coeur d'Alene) for EH staff this year. These trainings will be presented on an annual basis from now on.

1g. IDEQ is now in the process of developing a statewide Installer's Exam to be taken on line. This exam is now undergoing peer review in the IPHD.

1h. IDEQ will also conduct periodic program audits within each district. This has never happened before on any regular basis.

2a. In May 2010, IDEQ and the Attorney General's (AG) office reviewed all IPHD Board policies to determine whether they were in harmony, not in harmony, or independent of rule and statute. Based on that determination, policies were kept or rescinded. It has been discovered that IPHD Board policies do not carry the weight of law; therefore, District V has determined to rescind all external process policies.

2b. Fee schedule categories have been standardized across the state as of July 1, 2010. However, fee amounts vary from district to district based on local costs.

3a. District V had no rules to review. Districts III and IV rescinded theirs; and parts of District I were rescinded.

4a. The client appeal rule is according to IDAPA 41.08.01 statewide for now.

We feel that the IPHD and IDEQ have been very successful at meeting the requests of the Legislative Task Force this last year and hope that the concerns of the individuals involved have been met.



ENVIRONMENTAL HEALTH

Childcare

The goal of the childcare program is to ensure that all children in childcare settings are in a healthy and safe environment. In the 2009 legislative session, two things happened pertaining to childcare. The Idaho Public Health Districts were excluded as the regulatory entity giving IDHW the option of putting the contract out for bid; and IDHW was tasked with writing new childcare rules. Interestingly enough, when the invitation for bids was sent out, the only entity that came to the table was the group of seven Idaho Public Health Districts. We have the trained manpower to do the job that needs to be done. After much discussion and negotiation with IDHW, a single contract (using Central District Health Department as the Administrator) was signed which included all seven health districts.

In the 2010 session, the submitted rules did not pass with the major unresolved issue being staff to child ratios. We are, therefore, now functioning under temporary rules as declared by IDHW. This year these rules will be resubmitted with some modification to the ratios, and the fees will be submitted as a separate bill. Hopefully both will pass.

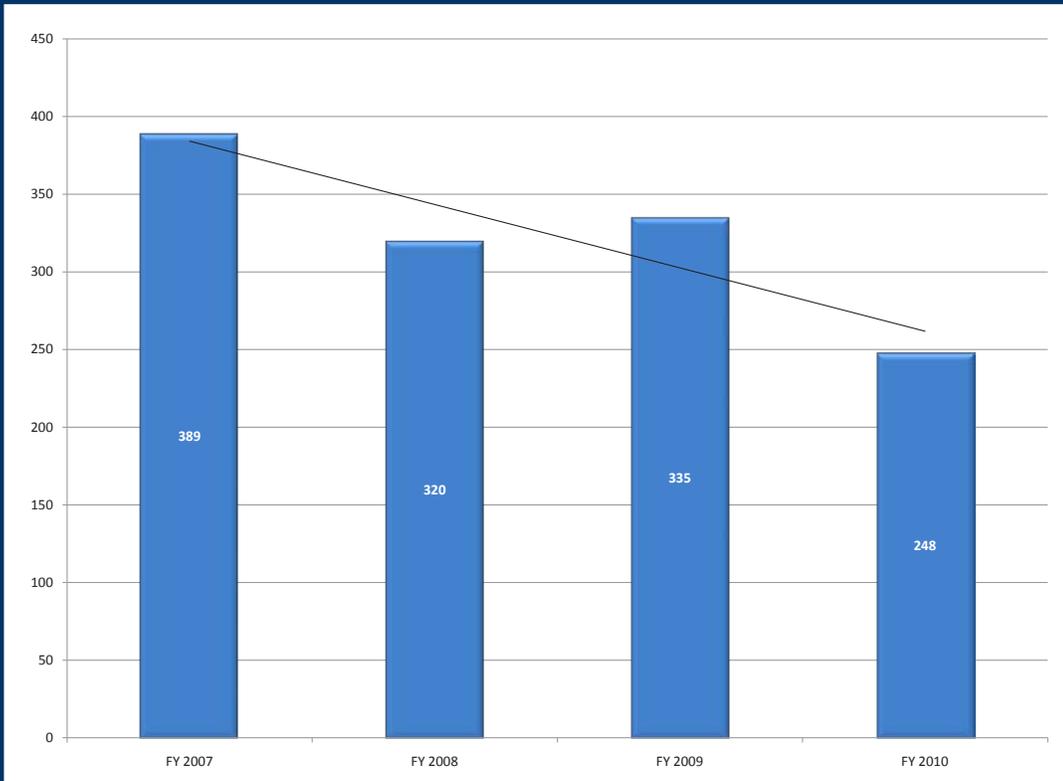
With the new contract, there was an increase in the scope of work, and this continues to expand due to IDHW's heavy dependence on the Idaho Public Health Districts.

For example:

- 1. Inspection checklist expanded from 21 to 29 items**
 - a. Firearm storage**
 - b. Water hazards**
 - c. Animal/pet vaccinations**
 - d. Tighter controls on staff ratios**
 - e. Random immunization checks**
 - f. Outdoor play areas**
 - g. Smoking and alcohol consumption on premises**
- 2. Individuals 13 years or older who have unsupervised access to the children must verify birth dates and Criminal History Background checks on site with the inspector.**
- 3. Complaint investigation: Districts will also be paid for receipt, response, and follow-up actions related to childcare complaints.**



Childcare Establishments



2007: establishments could receive three months ICCP checks prior to the deadline of meeting requirements of CPR instruction and background checks (some would then drop out of the system when that 90 day deadline was not met).

2008: the initial CPR and background checks were required prior to being eligible for ICCP checks. The number of establishments dropped significantly.

2009: the numbers began to rebound.

2010: the new temporary rules took effect (rules which are more restrictive on background checks, child ratios, and licensing requirements along with increased fees). Again the number of establishments has dropped. We feel that, as individuals come to understand the new rules and requirements, the numbers will again begin to climb—but probably more gradually over the next few years.



PUBLIC HEALTH PREPAREDNESS PROGRAM

The Public Health Preparedness program (PHP) at SCPHD was established in August 2002 upon receipt of Idaho's participation in the Center for Disease Control and Prevention Public Health Preparedness and Response Cooperative Agreement. The program expanded in August 2003 when responsibility to administer the Health Resources and Services Administration (HRSA, now ASPR) Hospital Bioterrorism Program was added. The PHP program expanded again in 2009 after receiving CDC Public Health and Social Service Emergency Funds for Public Health Emergency Response (to prepare for and respond to an influenza pandemic) and with funds to establish a Medical Reserve Corps.

In 2010, PHP staff updated our 21 plans; participated in 25 work force development trainings (involving 229 staff); planned, evaluated, and/or participated in 8 exercises and 11 real events; coordinated 4 regional health care planning meetings (representing 44 agencies); and established/renewed 15 MOUs. During its first year, over 50 residents have signed up to be members of the South Central Idaho Medical Reserve Corps.

Hospital Bioterrorism Prevention Program

Purpose: Upgrade the preparedness of the Nation's healthcare system to respond to bioterrorism, outbreaks of infectious disease, and other public health threats and emergencies

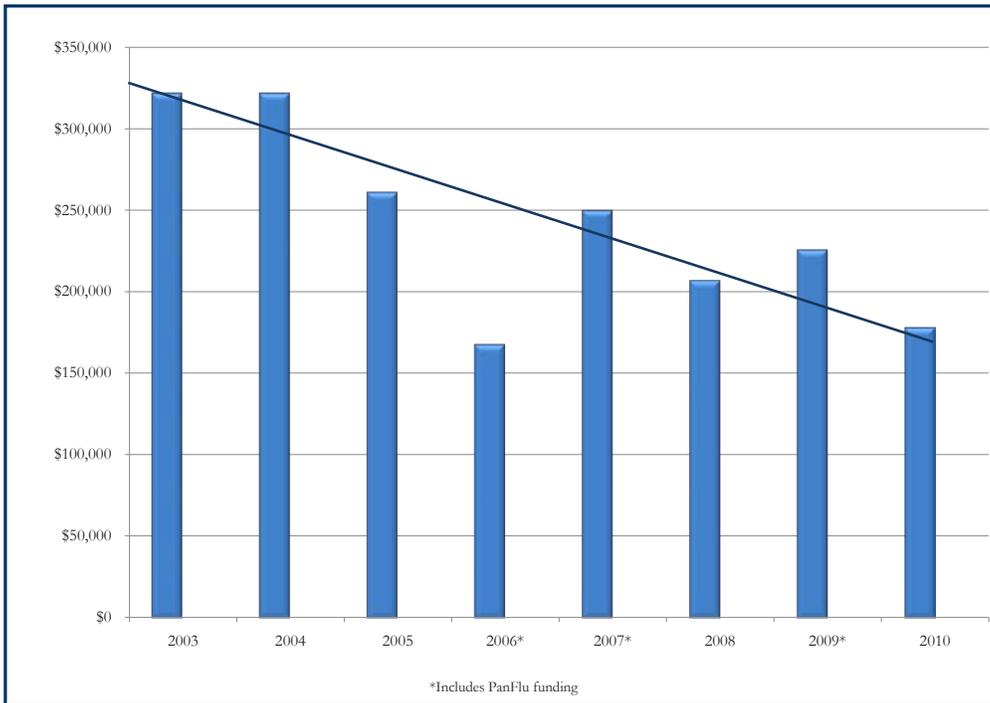
Participating Regional Health Care System Entities

- Cassia Regional Medical Hospital
- Minidoka Memorial Hospital
- Partners in Healthcare (formerly Gooding County Memorial Hospital)
- St. Benedict's Family Medical Center
- St. Luke's Magic Valley Hospital
- St. Luke's Wood River Medical Center
- Family Health Services
- Sawtooth Surgery Center
- Regional Emergency Medical Service (EMS) providers

**Total funding allocated to date: \$1,933,263
(2003-2010)**



Regional Health Care System Preparedness Funding



Regional Health Care System Capabilities at a Glance

- Interoperable Communications
 - Purchased communications equipment (satellite phones, 2-way radios, P25, handheld radios, TSP)
 - Upgrading equipment to new 700 MHz capability
 - Purchased and implemented Everbridge Communication System utilized by 5 hospitals
- Medical Assets
 - 24 ventilators
 - 20 bariatric equipment (wheelchairs, lifts, sleds)
 - 219 staffed bed capacity
 - 48 isolation beds
- Medical Reserve Corps / Volunteer Idaho!
 - Recruited 50 medical reserve core volunteers
 - Exercised system to activate volunteers
- Fatality Management
 - Purchased and outfitted 2 mass fatality trailers maintained at 2 hospitals
 - Minidoka Memorial Hospital
 - Partners in Health (formerly Gooding County Memorial Hospital)
- Medical Evacuation
 - Purchased and outfitted shelters/tents (mobile medical/alternate care site/evacuation)
 - Full Scale Exercise of equipment
 - Identified 17 “fixed” alternative care sites and 11 “mobile” sites throughout the district
- Bed Tracking System
 - Implemented/trained hospital staff on statewide bed tracking
 - Exercised system to identify available hospital beds in region
- Exercises and Training
 - 9 Table-top through Full Scale Exercises involving over 1000 participants in 6 counties
 - 11 Training sessions with over 160 participants (ICS/NIMS, Communications, Decon, Equipment)



