

Healthy Shasta County 2010

A Long Term Strategic Plan

Shasta County Public Health
September 2004
Updated March 2007
Updated March 2008

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Letter from Shasta County Health & Human Services Director, Public Health Director & Health Officer

Thank you for your interest in the Healthy Shasta County 2010 Strategic Plan. The goal of our strategic plan is to effectively serve the residents and visitors of Shasta County by focusing our efforts on health outcomes based on local data, best practices and community input.

The pages that follow reflect the goals and strategies to promote specific health outcomes the department will strive to implement through 2010. This plan could not have been completed without the input and support of many individuals and organizations, including staff, Public Health Advisory Board members, and our community partners. They provided input into the refinement of our vision and mission statements and the development of our values statement, reviewed health data, researched best practices, and developed a list of priority health outcome areas and strategies. We truly appreciate the dedication to public health that has been exhibited by staff and the community during this process.

Shasta County Public Health actively works with communities to protect and improve the health of our residents and we believe our strategic plan will help steer the Department's activities, serve as a resource for our community, and, most importantly, result in a healthier Shasta County for all.

Sincerely,



Marta McKenzie, RD, MPH
Shasta County Health &
Human Services Agency Director



Donnell Ewert, MPH
Shasta County Public Health
Director



Andrew Deckert, MD, MPH
Shasta County Health Officer

Letter from the Public Health Advisory Board (PHAB)

March 2007

Dear Shasta County Board of Supervisors:

It is my pleasure to present the updated Healthy Shasta County 2010 strategic plan to you. Many Advisory Board members participated in the review and revision of this plan and the Board took formal action to accept the revised strategic plan at its February 2007 meeting. The strategic plan accurately reflects the priorities of the department to protect and improve the health of Shasta County residents and visitors. The Public Health Department staff and the Board of Supervisors are to be commended for their vision and commitment to serve the community. We, the Advisory Board, are confident this plan will continue to serve as a road map toward a healthier Shasta County for all.

This plan outlines the strategies that address 13 of the health outcomes endorsed by the Public Health Advisory Board. With the multitude of opportunities and issues available, this plan will focus the efforts of the Public Health Department, thereby maximizing investments and improving outcomes for priority issues.

As Advisory Board members, we receive regular reports on the progress of this plan's implementation. We thank you for the opportunity to advise the Public Health staff and will continue to assist them, as best we can, to meet these important goals.

Respectfully submitted,

Kimberly A. Niemer
Chair 2006-07



Acknowledgements

Our sincere gratitude goes out to the following individuals and organizations for their contribution to our strategic plan:

Allen Krohn, MD*	RIOH/Crossroads Clinic
Andrew Hinds*	East Cottonwood Elementary School
Betty Futrell	Child Abuse Prevention Council
Brad Tillson*	Blood Source – North State
Carollyn Chapman, RN*	Retired
Catherine Ley	Mercy Medical Center
Cathleen Wyatt*	PHAB Member
Cindy Dodds*	Tri County Community Network
Colleen Tanenbaum	Shasta County Drug and Alcohol Programs
Curtis Wood	Shasta County District Attorney
Cap. Dave Hahn	California Highway Patrol
Dean Germano*	Shasta Community Health Center
Debbie Peel	First 5 Shasta
Eric Hanson*	Hanson Glass and Mirror Co.
Fred Wyckoff*	Shasta Lake Fire District
Gary Dirks	Redding Police Department
Gloria Espinosa-Hall, RD, MPH	UC Cooperative Extension
Jeff Chinn*	Redding Medical Center
John Pecaut	Shasta Driving School
John Truitt	Family Planning, Inc.
John Zapp, MD*	Mercy Medical Center/Retired
Kim Niemer*	City of Redding
Kimberly Fancher	Shingletown Hwy 44 Safety Project
Linda Cadd	Shasta County Women’s Refuge
Lori Juszak*	True North
Mana Davis*	Senior Services Consultant
Mary Jensen	Shasta County Women’s Refuge
Marie Whitacre*	Shasta Board of Realtors
Melinda Brown*	People of Progress
Monty Hight	California Highway Patrol
Nancy Bolen	Local Interagency Network for Children and Family Services
Nancy Geer	Shasta County Probation
Patti Field	Shasta County Probation
Paula Percy, RN*	Redding Medical Center
Richard Ryan	Shasta County Children and Family Services
Sally Riley*	Construction Industry Force Account Council
Susie Evans	Shasta County Women’s Refuge
Tom Taylor	Shasta County Children and Family Services
Tom Wright	Wright Education Services
Toni Rango*	Medical Home Care Professionals

*Current or former member of the Public Health Advisory Board (PHAB)

We thank the many other individuals who participated and regularly contribute to Public Health.

Executive Summary

Because Shasta County Public Health envisions healthy people in healthy communities, our mission is to work with communities to protect and improve health. We strive to conduct our work with compassion for people, in collaboration with community partners, emphasizing prevention, trying to serve everyone, and with honesty and accountability. Our department is organized around our strategic goals for this decade with the following branches: Children's Health Services, Nutrition and Physical Activity, Tobacco Education and Injury Prevention, Communicable Disease Prevention and Control, Maternal and Child Health, and Regional Community Health Improvement. We serve a population that is predicted to grow from 163,256 in 2000 to 212,947 in 2010.

Our long-term strategic plan focuses on ten health outcome areas that were ranked as most important through a collaborative prioritization process. The purpose of the plan is to communicate our department goals to our staff and communities, to guide management in decision making, to guide staff in program planning, and to inform staff and communities about the current best practices related to health protection and improvement.

Four of the ten focus areas are related to chronic disease prevention. To prevent exposure to **tobacco**, our strategies include increasing community awareness about the harmful effects of second-hand tobacco smoke, increasing availability and access to tobacco cessation services, and collaborating with community partners to prevent youth initiation of tobacco use. The foci of our **physical activity** promotion strategies are designing and implementing a countywide campaign promoting physical activity, increasing physical activity opportunities for children in the school setting and in the community, and advocating for changes in the built environment that promote physical activity. **Healthy eating** strategies include designing and implementing a comprehensive campaign to promote eating fruits and vegetables daily, supporting communities and schools in offering more healthy food options, partnering with community agencies and families to improve childhood nutrition, and assisting mothers in overcoming barriers to breastfeeding. **Oral health** strategies focus on improving access to fluoride, dental care and education to improve oral health in Shasta County children.

Our plan focuses on three health outcomes related to injury prevention. To address **motor vehicle crash injuries and deaths**, we intend to reduce the prevalence of driving under the influence of alcohol and other drugs, increase the use of safety equipment such as seatbelts, and to improve the safety of built environments for biking and walking. In the area of prevention of **family violence**, we plan to educate the community about the underlying causes of violence, to promote changes in community norms related to violent behavior, advocate for changes in policies that tolerate or perpetuate violence, increase health provider screening for family violence, and reduce alcohol and other drug abuse. We will work with primary care physicians and youth and senior serving organizations to screen for and identify persons at risk for **suicide**. We will work with local agencies to reduce access to lethal means and methods of self-harm.

Two focus areas address communicable disease prevention. General **communicable disease** prevention strategies focus on increasing immunization against vaccine-preventable diseases, tuberculosis control, preventing infection with blood-borne pathogens, decreasing transmission of sexually transmitted diseases, and improving laboratory capacity. Preparing for **bioterrorism and other emergencies** is another area of focus for the department. Strategies to achieve preparedness include collaborating with important community partners in planning, increasing frequency of training and practice, improving surveillance and investigation capacity for biological agents that may be used by terrorists, and developing effective health alert and crisis communication systems.

The final focus area is unlike the others in that it addresses a segment of the population, rather than a health outcome. **Senior health and wellness** addresses several health outcomes and behaviors of importance to our older residents related to chronic disease prevention (physical activity, nutrition, and diabetes) and injury prevention (falls and depression/suicide).

Our Vision, Mission, and Values

Vision

Healthy people in healthy communities.

Mission

Working with communities to protect and improve health.

Values

Compassion

Caring about people

We value people, and seek for all individuals a long and high-quality life free from disease and disability. We strive to treat all people with dignity, respect, and in a confidential manner.

Community Collaboration

Working with partners

We believe that residents know their communities best and have a vested interest in their well-being. We partner in innovative ways with communities and other stakeholders to create healthful places to live, work, and play.

Prevention

Creating and preserving health

We strive to prevent suffering and the cost of disease whenever possible. We address health issues through the full spectrum of prevention, from working for increased health awareness or behavioral change in individuals, to system and policy change. We use facts discovered through scientific methods to establish and evaluate programs, interventions, and policies to improve health.

Equality

Serving everyone

We strive to serve every person living in or visiting Shasta County in a culturally sensitive and appropriate manner. We work toward the elimination of health disparities between groups of people. Every community in the county is important to us, and we seek to assure that each has access to important preventive and other health services.

Integrity

Accountable and honest

We aim to do the most possible to protect and improve health with the financial resources available to us, always striving to make efficient and productive use of the public's funds. We are committed to honesty in all of our activities, transparency in decision-making and information sharing, and sincerity in our relationships.

Who We Are

Shasta County Public Health is a progressive health department dedicated to working with communities to protect and improve health. Our work is characterized by a public health approach that seeks to eliminate disease in entire populations through primary prevention (preventing health problems before they occur) with a strong commitment to community participation. A fundamental principle of our approach is that health problems are not *solely* caused by individual choices, but by community conditions and norms. Our emphasis for improving health and preventing disease is to develop policies and support community environments that are conducive to healthy behaviors. We employ strategies that are based on best practices using interdisciplinary methods that include public and private organizations, schools and workplaces. The department is organized into the following divisions to most efficiently work on common or similar health problems.

The **Administration Services Division** provides overall leadership and direction to the department through senior administrative managers and the health officer. The division also offers support to the five program divisions through its *Fiscal and Contracts, Assessment and Evaluation, Community Relations, and Employee Development and Support* units.

The **Health Support Services Division** works to assure access to health services for children through four programs. *California Children's Services (CCS)* provides diagnostic, therapy, and treatment services, as well as medical case management to children under age 21 with certain physically disabling conditions. *Child Health and Disability Prevention (CHDP)* provides comprehensive well-child assessments for early detection and prevention of disease and disabilities through a network of providers. The *Childhood Lead Poisoning Prevention Program (CLPPP)* provides community and provider education and case management of lead-poisoned children. The *Social Services Nursing Program* provides medical and dental case management services to children in foster care.

Two divisions were created from the restructuring of the former Chronic Disease and Injury Prevention Division. The **Nutrition and Physical Activity Promotion Division** will consist of programs focusing on worksite wellness, built environment, nutrition and physical activity, including Nutrition Network, LEAN, Worksite Wellness, Healthy Beginnings, Healthy Shasta and Healthy Communities. The **Injury and Substance Abuse Prevention Division** will include tobacco, injury, senior health, and the new areas of drug and alcohol prevention, and suicide prevention.

The **Communicable Disease Prevention and Control Division** works to prevent and control the spread of communicable diseases. Staff are responsible for communicable disease investigation, sexually transmitted disease (STD) services, immunization services, HIV testing, counseling and education, bioterrorism and disaster preparedness, and laboratory services. The laboratory serves as a regional public health laboratory for six other Northern California counties.

The **Maternal and Child Health Division** works to protect and improve the health of mothers, children, teenagers, and their families. *Women, Infants, and Children (WIC) Supplemental Nutrition Program* provide food vouchers and counseling to low-income women and their infants and children under age five. Staff in the *Maternal, Child, and Adolescent Health Unit* advocate for children's health and promote attention to women's health concerns, provide early screening and identification of families at risk for child abuse, neglect, substance abuse, family violence, and provide services and support to increase the initiation and duration of breastfeeding.

The **Regional Community Health Improvement Division** works to provide a geographic and community infrastructure for all of the department's activities. Staff are located in regional teams in Redding and in the East, Northwest, and Southwest parts of Shasta County. In addition to taking many department programs to residents in rural areas, regional staff members work directly with community partners using models that embrace "community driven" health improvement, which involve listening in a deliberate way to local community members and groups to determine what issues are important to them and developing a plan of action together.

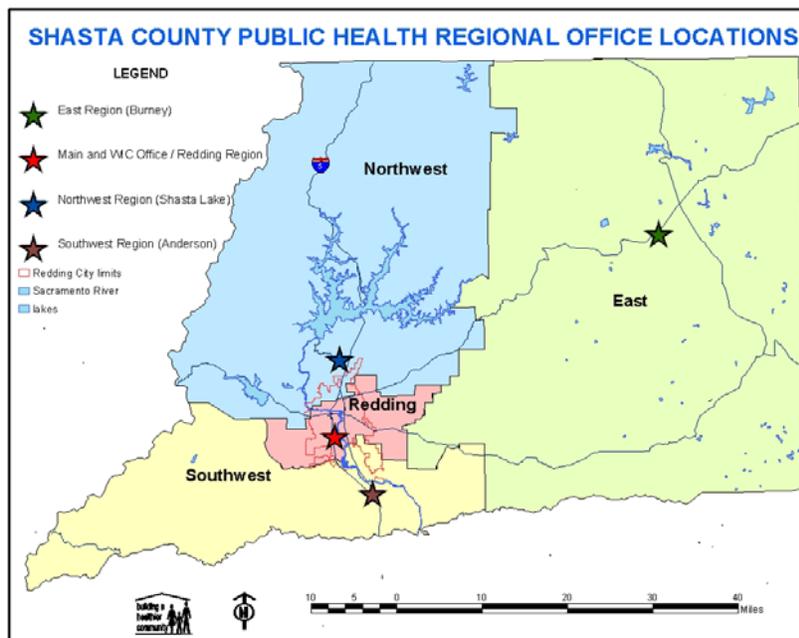
Who We Serve

Shasta County occupies approximately 3,785 square miles of terrain. Most of the county is mountainous and rural but has three incorporated cities: Redding, Anderson and the City of Shasta Lake.

Shasta County Population By Age and Ethnicity:

Age Groups	2000 U.S. Census Bureau	2010 CA Department of Finance Projections*
Total County Population:	163,256	212,947
Population Under 18:	42,674	50,710
Young Children: (0-4)	9,643	14,446
K-6 Population (5-9):	11,591	14,088
Middle School (10-14):	13,296	13,809
High School (15-19):	12,856	14,391
Adult (20-64):	91,009	122,877
Senior (65+):	24,861	33,336
Ethnic Groups	2000 U.S. Census Bureau	2010 CA Department of Finance Projections*
Total County Population:	163,256	212,947
White	145,826	187,166
Hispanic or Latino (of any race)	8,998	11,633
American Indian/Alaska Native	4,528	5,362
Asian / Pacific Islander	3,226	7,119
Black or African American	1,225	1,667
Other Race/2 or more races	8,451	N/A

* This projection is based on the 1990 Census count. Based on more current estimates, this projection overestimates the size of Shasta County's population in 2010 but is the most current projection available.



Overview of the Strategic Plan

Long-term planning is necessary to achieve maximum effectiveness in protecting and improving health in Shasta County. The Department set aside staff time and included its Public Health Advisory Board (PHAB) and community partners to create a plan that would focus on specific health outcome goals to be achieved by the year 2010. The planning process was divided into various activities:

- Updating our mission statement,
- Identifying our vision statement and organizational values,
- Identifying legal mandates and public health stakeholders,
- Conducting a survey among community members to assess the public's priority health areas,
- Compiling and reviewing data from all recent Shasta County health assessments, and
- In collaboration with the Public Health Advisory Board, identifying priority health areas on which to focus our efforts.

The criteria used to rank the importance of health outcomes included (1) ability to change the health outcome, (2) number (or rate) of cases or events, (3) impact on quality of life, (4) community identified needs/community perception, (5) availability of resources to address the issue, (6) costliness of treatment or consequences, and (7) the trend related to the issue (increasing or decreasing).

Seventeen Priority Health Areas
Tobacco Use
Motor Vehicle Injury/Death
Communicable Disease
Obesity
Physical Inactivity
Alcohol Abuse
Family Violence
Senior Health
Poor Nutrition
Disaster Preparedness
Other Substance Abuse
Other Violence
Oral Health
Depression/Suicide
Access to Health Care
Hepatitis C
Environmental Health as it relates to Asthma, Lead, and Environmental Tobacco Smoke

We focused our planning and implementation efforts on the 10 highest ranked health priority areas. We are committed to making progress in the other areas also, but acknowledge that collaboration with other agencies is critical in these areas. The strategies and activities presented in this plan were chosen by workgroups made up of public health staff and community partners based on epidemiological data, resource availability, political feasibility, and public health best practices.

Purpose of the Strategic Plan

The goal of the strategic plan is to protect and improve the health of residents and visitors of Shasta County by focusing on health outcomes that are based on health data and community input. The plan has many uses, including the following:

- ▣ To help communicate department goals to the community, potential funders and local and state level decision makers,
- ▣ To act as a guide for management when choosing funding streams and determining how department resources should be allocated,
- ▣ To act as a guide for staff to ensure that their individual program activities and goals are in alignment with the department's health outcome goals,
- ▣ To help staff and communities utilize health improvement strategies that seek to eliminate disease in entire populations through primary prevention, and
- ▣ To work towards changing organizational practices, community norms, and environments to promote healthy behaviors and ultimately improve the community's health.

Health problems are not *solely* caused by individual choices, but by community environmental conditions and norms that influence health behaviors.

Crosscutting Strategies

Several strategies arose during the planning process that are relevant to every health focus within this document. Instead of repeating them throughout the document, they are highlighted here.

- ▣ **Prevention:** Our priority is always to prevent health problems before they start.
- ▣ **Regional approach:** We have offices in each of four regions within the county, with staff dedicated to protecting and improving health in their assigned geography. We will use this infrastructure to do the work outlined in this plan.
- ▣ **Cultural sensitivity:** Our community has a small but growing population of ethnic minorities, and we are dedicated to eliminating disparities in health outcomes among these groups, and to serving them in a culturally sensitive and appropriate manner.
- ▣ **Youth developmental assets:** Increasing developmental assets among children and youth is a proven strategy that prevents risky behaviors that lead to many diseases and injuries.
- ▣ **Social conditions and environment:** Health is impacted by genetics, social relationships, personal behaviors, access to healthcare services, and economic status. While individual choices are important, many choices are heavily influenced by the local social and economic environment.
- ▣ **Community partnerships:** Our work can effectively reach all communities in the county only if we partner with community-based and grassroots organizations that know their communities well.

Health Priority Areas

Tobacco Use Prevention

Tobacco use remains the #1 cause of preventable death and disease in the U.S., yet 19% of Shasta County adults smoke and 4% use smokeless tobacco (PRC2002). The harmful effects from smoking have long been documented, beginning with the 1964 Surgeon General Report on the health effects of smoking. Smoking has been linked to a variety of diseases including lung, kidney and stomach cancer, rheumatoid arthritis, respiratory disease and heart disease. Not only does tobacco use cause health problems for the smoker; but also individuals who are exposed to secondhand smoke, especially children who often suffer from tobacco-related health problems. Although quitting smoking poses a challenge for many people, there are significant health benefits at any age that can be gained from quitting at any age. However, since smoking addiction can and often does start in childhood, preventing tobacco initiation among children and youth is a best practice in public health. It is our vision that no child living in Shasta County should be exposed to tobacco smoke. With these factors in mind, the Department has developed strategies that focus on reducing tobacco use and exposure to secondhand smoke.

Public Health's Approach to Tobacco Use:

1. Increase community awareness among Shasta County residents about the harmful effects of secondhand smoke.
2. Collaborate with community partners to develop policies that prevent youth tobacco initiation.
3. Increase availability of and access to services in Shasta County that help people to quit smoking and chewing tobacco.



Tobacco Use Prevention 2010 Goal:

Reduce tobacco use and exposure to secondhand smoke.

Tobacco Use Prevention Measurements of Success:

1. By December 2010, decrease the percentage of children aged 0 – 6 years who are exposed to secondhand smoke in the home to 8%. (Baseline: 12%, Source: PRC2002).
2. By December 2010, decrease the percentage of women who report smoking at any time during pregnancy to 12%. (Baseline: 15%, Source: OSHPD 2000).
3. By December 2010, reduce the prevalence of cigarette smoking among persons aged 18-39 years to 18%. (Baseline: 24%, Source: PRC2002).
4. By December 2010, decrease the percentage of 7th, 9th and 11th grade students who have smoked cigarettes on one or more days in the past 30 days to 10%. (Baseline: 17%, Source: CHKS2004-05).
5. By December 2010, decrease the percentage of 7th, 9th and 11th grade students who have used spit tobacco on one or more days in the past 30 days to 3%. (Baseline: 5%, Source: CHKS2004-05)



Tobacco use remains the #1 cause of preventable death and disease in the U.S.

Tobacco Use Prevention Action Steps:

1. Design and implement an educational campaign that focuses on the effects of secondhand smoke on children, and tobacco use during pregnancy.
2. Promote policy and environmental changes to reduce exposure to secondhand smoke.
3. Encourage and support tobacco cessation services that target pregnant women, teens, and parents of young children.
4. Provide technical assistance to schools and youth serving organizations regarding tobacco-use prevention among youth.
5. Strengthen the capacity and focus of the Tobacco Education Coalition.
6. Research and implement effective strategies to reduce youth access to tobacco through social (friends and family) and commercial sources.
7. Support local efforts regarding effective licensure of businesses that sell tobacco products.

Motor Vehicle Injury Prevention

Nationwide, more than three million people were injured as a result of motor vehicle crashes in 2001. Motor vehicle crashes are the leading cause of death for Americans between the ages of two and 33 years. Economically, crashes cost our society approximately \$230.6 billion a year in medical care and damaged vehicle costs. Alcohol, failure to use seat belts, or misuse of seat belts and child safety seats are major contributing factors to motor vehicle fatalities.

Alcohol, failure to use seat belts, or misuse of seat belts and child safety seats are major contributing factors to motor vehicle fatalities.

Motor vehicle crashes are the most important cause of unintended injuries in Shasta County, responsible for 42% of all unintended injury deaths in 2002. A major cause of motor vehicle crashes in Shasta County is alcohol. In 2002, alcohol was involved in 35% of all fatal collisions. Furthermore, 42% of persons injured or killed in motor vehicle crashes were not wearing seatbelts. Prevention strategies focus on increasing usage of seat belts, child safety seats, bicycle helmets, and increasing implementation of programs to reduce the presence of drunk and drugged drivers on our roads, including improved enforcement and penalties. Keeping these best practices in mind, the department chose to focus on the strategies outlined below.

Public Health's Approach to Motor Vehicle Injuries:

1. Reduce the prevalence of driving under the influence of alcohol or other drugs.
2. Increase proper seat belt and child safety seat use.
3. Increase safe bike and pedestrian environments and practices.



Motor Vehicle Injury Prevention 2010 Goal:

Decrease the number of injuries and fatalities incurred by occupants, bicyclists and pedestrians as a result of motor vehicle crashes.

Motor Vehicle Injury Prevention Measurements of Success:

1. By December 2010, reduce the percentage of all motor vehicle fatalities that are alcohol-related to 25%. (Baseline: 32% Source: SWITRS 2002)
2. By December 2010, maintain child safety seat compliance among those that are involved in a collision at 95%. (Baseline: 95%, Source: SWITRS 2005)
3. By December 2010, increase seat belt compliance rate for adult motor vehicle occupants to 95%. (Baseline: 89% Source: PRC 2002)
4. By December 2010, increase reported bicycle helmet usage among children aged less than 18 years to 70%. (Baseline: 62%, Source: PRC 2002)



Motor Vehicle Injury Prevention Action Steps:

1. Conduct and support motor vehicle safety and injury prevention classes and presentations in the community.
2. Conduct and support an educational campaign that addresses driving under the influence (DUI), seat belts, child safety seats, and bicycle helmets.
3. Ensure the availability of low-cost bicycle helmets and child safety seats in the community.
4. Encourage increased enforcement of traffic safety laws pertaining to DUI, seat belts, child safety seats, bicycle helmets, and graduated driver licensing (GDL).
5. Support legislative efforts to increase penalties (high fines and points on the drivers license) for driving offenses such as DUI, reckless driving, and speeding.
6. Support legislative efforts and provide community education promoting the quality of driver's education/training and the graduated drivers licensing (GDL) law.
7. Support legislative or local efforts to increase alcohol tax, to restrict alcohol advertising, and decrease availability of alcohol to minors.
8. Support court systems and law enforcement in enforcing conditions of probation/parole for DUI offenders.
9. Encourage the District Attorney and judges to not drop or reduce charges/penalties for DUI, sales of alcohol to minors, minors' possession of alcohol, and providing alcohol to minors.
10. Promote Safe Routes to School programs and development of pedestrian and bike-friendly built environment such as more bike lanes, bike triggered stop lights).
11. Support community efforts to develop and maintain Mothers Against Drunk Driving and Students Against Drunk Driving chapters, sober graduation parties, and involvement of victims in sentencing of DUI offenders.

Communicable Disease Prevention

Protecting people from the human and economic costs associated with disease is a core public health function. Infectious diseases remain major causes of illness, disability, and death around the world. New infectious agents and diseases are being discovered every year, and some diseases considered under control have re-emerged in recent years. Through communicable disease investigation and intervention (immunization services, STD services, HIV testing and counseling, community education, and laboratory services), SCPH works to prevent and control infectious diseases and epidemics. Keeping best practices in mind, the following strategic directions have been selected to prevent and control communicable diseases in our communities.

Public Health's Approach to Communicable Disease:

1. Improve surveillance, laboratory testing, reporting, tracking, investigation, and intervention capacity for communicable diseases.
2. Develop and strengthen more partnerships with healthcare providers and other community agencies to screen and detect communicable diseases, to offer immunizations, to coordinate responses and to educate clients and the public.
3. Promote risk-reduction strategies to decrease transmission of sexually transmitted and blood-borne pathogens.
4. Provide or assure aggressive treatment and follow-up for persons with active TB disease and higher-risk latent tuberculosis infections.
5. Establish a fully operational, population-based Immunization Registry for Shasta County.

Preventing communicable infections protects individuals, families, and society from the physical, emotional, and economic impact of disease.

Communicable Disease Prevention 2010 Goal:

To reduce the incidence of communicable diseases in Shasta County.

Communicable Disease Prevention Measurements of Success:

1. By 2010, reduce the incidence of vaccine-preventable diseases.
 - Increase to 85% the percentage of children who by the age of two have received these universally recommended vaccinations for children (4 DTaP; 3 Hib; 3 Hep B; 1 MMR; 3 IPV; 1 Varicella; 4 Pneumococcal). (Baseline: 74%, Source: CASA 2002-03)



- Increase the percentage of children younger than six who participate in fully operational, population-based immunization registries to 50%. (Baseline: 0%, Source: SCPH 2004)
 - Increase the percentage of non-institutionalized adults 65 and older who received flu vaccination on a yearly basis to 75%. (Baseline: 68%, Source: PRC2002)
 - Increase the percentage of non-institutionalized adults 65 and older who have ever received a pneumococcal vaccination to 75%. (Baseline: 65%, Source: PRC2002)
2. By 2010, reduce incidence of air-borne infections.
- Increase the percentage of infected contacts of current active tuberculosis disease cases with latent tuberculosis infection who start and complete a course of treatment to 85%. (Baseline: 31%, Source: SCPH 2001-2003)
 - Reduce incidence of new tuberculosis cases to 1.0 case per 100,000 population. (Baseline: 2.7 per 100,000, Source: SCPH 2002)
3. By 2010, reduce incidence of blood-borne infections.
- Reduce the incidence of acute Hepatitis C to 1 case per 100,000 population. (Baseline: 2.8 per 100,000, Source: SCPH 2002)
 - Reduce the incidence of acute Hepatitis B infections to 4.0 cases per 100,000 population. (Baseline: 16.3 per 100,000, Source: SCPH 2002)
 - By 2010, the annual number of free HIV counseling and testing services provided to injection drug users and their partners by Shasta County Public Health will increase by 25%. (Baseline: 247 IDUs and partners tested, Source: SCPH 2005)
- 
4. By 2010, reduce incidence of sexually transmitted infections.
- Reduce the prevalence of *Chlamydia trachomatis* infections among 15-24 year-old females attending family planning clinics to 3%. (Baseline: 5%, Source: FPI/SCPH 2002)
 - Reduce the prevalence of *Chlamydia trachomatis* infections among females aged less than 18 years booked and tested in juvenile detention centers to 5%. (Baseline: 13%, Source: SCPH/CIaSP 2003)
5. By 2010, improve capacity to provide comprehensive laboratory services to support essential communicable disease diagnosis and control.
- Decrease time to identify MTB complex in AFB-positive smears with DNA probe. (Baseline: 14 days, Source: SCPH Lab 2004)
 - Complete lab upgrades to become a Reference Laboratory (Level B). COMPLETED.

- Increase menu/list of lab services offered by 20% by 2010. (Baseline: 25 services, Source: SCPH Lab 2004)

Communicable Disease Prevention Action Steps:

1. Continue to work with providers to implement current and emerging immunization standards, including standing orders – or equivalent -- for children and adults as recommended by Centers for Disease Control and Prevention (CDC) and/or California Department of Health Services.
2. Ensure providers submit complete Confidential Morbidity Reports and HIV/AIDS Case Reports in a timely fashion by working with providers and labs, conducting compliance site visits, auditing patient charts, and exploring/utilizing emerging technologies to improve reporting.
3. Implement an electric, web-based reporting system for Confidential Morbidity Reports when compatible statewide technology is available.
4. Offer technical assistance and education to providers for implementing protocols, standards of care, and screening tools to decrease incidence of known and emerging communicable diseases.
5. Enhance immunization, screening, treatment, and partner notification services to interrupt disease transmission in populations at risk.
6. Enhance communication with providers through the SCPH web site, Provider News newsletter, broadcast faxes, etc., and the public through awareness campaigns and media to promote prevention messages.
7. Continue to promote sexual abstinence, monogamy, condom use, and other risk reduction strategies.
8. Continue to support school-based educational efforts to prevent disease transmission.
9. Participate on local Boards of Directors, community groups, and task forces that address communicable disease issues.
10. Maintain the increased capacity of the lab to process specimens from other jurisdictions, and actively pursue appropriate new testing services and technologies.
11. Continue to incorporate technologies that more rapidly and accurately identify and confirm infectious agents.
12. Continue to implement activities to prevent transmission of blood-borne pathogens through used syringes and needles.
13. Continue to explore possibility of funding and other resources to address emerging infectious disease problems (e.g. West Nile Virus, methicillin-resistant *Staphylococcus aureus* {MRSA}, other antibiotic resistant pathogens, etc.)



Physical Activity Promotion

Being physically active can be one of the easiest and most inexpensive ways to help prevent a variety of chronic diseases. In 1996, the Surgeon General released a report based on the first comprehensive study looking at the connection between health and physical activity. The consensus among epidemiologists, exercise experts, and health professionals is that just 30 minutes of moderate to vigorous intensity exercise on five or more days per week for adults, and 60 minutes for children, is enough to improve health and quality of life. In Shasta County, almost 57% of adults and 30% of children do not meet the recommended requirements. Prevention techniques include community-wide campaigns, increasing quantity and quality of PE and after-school recreation programs, and advocating for local land use changes that decrease our dependence on cars and give people greater access to parks, walking trails, and bike lanes. Keeping these best practices in mind, the department looked at local trends in physical activity among all ages and chose to focus on the following strategies to address physical activity locally.

Public Health's Approach to Physical Inactivity:

1. Design and implement a comprehensive campaign promoting physical activity and the variety of opportunities that exist in Shasta County.
2. Increase physical activity opportunities for children, and youth at schools, families and community members.
3. Advocate for changes in the built environment that promote access to physical activity opportunities.



Physical Activity 2010 Goal:

Increase physical activity among Shasta County residents.

Physical Activity Measurements of Success:

1. By December 2010, increase to 30% the percentage of adults who participate in moderate physical activity at least 5 times per week for at least 30 minutes a day. (Baseline: 21%, Source: PRC2004)
2. By December 2010, decrease to 45% the percentage of adults ages 18 and up who are sedentary. (Baseline: 57%, Source: PRC2002)

Promoting physical activity at schools and worksites can help prevent a variety of chronic diseases.

3. By December 2010, increase the percentage of school-aged children who are physically fit, defined as those 5th, 7th, and 9th graders who pass at least 5 of the 6 standards on the California Fitnessgram, to 75% or more. (Baseline: 62%, Source: CDE Fitnessgram Results 2002-03)
4. By December 2010, increase to 35% the percentage of Shasta County residents who use local trails for walking, hiking, or biking at least once a week in good weather. (Baseline: 28%, Source: PRC2004)

**Physical Activity Action Steps:**

1. Educate policy makers, planning commissioners and developers on the importance of community-built environments that support physical activity.
2. Develop a social marketing campaign that promotes walking and promotes community-based physical activity opportunities.

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3. Advocate for and support community-driven physical activity related initiatives such as non-competitive youth activities, scholarships for sports participation and family fitness activities.
4. Work with providers to incorporate a physical activity component into after-school and summer day camp programs.
5. Advocate for legislation and work with school districts to expand and improve the quality of physical education and Fitnessgram testing.
6. Educate and provide technical assistance to school administrators, school boards and after-school program directors to improve the quality and quantity of physical activity opportunities at school sites.
7. Support legislation and seek resources that increase access to open space, parks and safe bike ways and pedestrian paths, trails and sidewalks.
8. Advocate for land use strategies that foster connectivity and support walking and bicycling as a means of alternative transportation.
9. Assist schools in overcoming obstacles to making school grounds and facilities available to the public for physical activity on a regular basis.
10. Educate and enable parents and child care providers to reduce television, computer and video screen time and to increase physical activity among children.
11. Support legislation and seek resources that increase the consideration of health impact in land use decisions.
12. Develop a local system to measure the health impacts of the built environment such as the amount of linear miles of bike ways, trails and sidewalks per person, or acres of developed park land per person.

Children should get 60 minutes of moderate to vigorous intensity exercise on five or more days per week.



Family Violence Prevention

Once considered a private matter, violence in the family is now recognized as a significant problem for our society. It includes partner emotional and verbal abuse, partner physical and sexual abuse, child physical and sexual abuse, child neglect, dating violence, and physical/emotional abuse of older family members. Family violence is a significant, underlying cause of poor health, injuries, mental illness and disability in women and children and causes serious health and economic consequences for individuals, families and communities. In addition, men can also be victims of intimate partner violence.



Child abuse and intimate partner violence (IPV) are linked and have serious consequences for the safety of children. Family violence is often intergenerational as partner violence. Child maltreatment and youth violence tend to occur in the same families and perpetuate one another. Victims of child abuse may continue the cycle of violence within dating relationships, adult partner relationships and relationships with an older parent. Studies show that abuse and neglect puts victims at high risk for alcoholism, drug abuse, suicide, depression, obesity and other chronic diseases later in life. Most perpetrators of family violence exhibit one or more of the following characteristics: history of alcohol/substance abuse, depression, aggressive behaviors, incarceration, low self-esteem, or history of physical or other abuse themselves.

Although family violence has traditionally been addressed through social services and law enforcement, it is increasingly recognized as an issue that encompasses the social determinants of health. Violence stems from complex personal, social, and economic causes such as poverty, discrimination, lack of education, and lack of employment opportunities. As such, violence prevention calls for multi-faceted efforts including the resources of institutions and systems such as grassroots organizations, family, education, health, business, criminal justice, and social services. The Department will focus on child abuse and intimate partner violence prevention using the following strategies.

Public Health's Approach to Family Violence:

1. Cultivate peaceful conflict resolution as the community norm for interpersonal relationships.
2. Decrease exposure of children and youth to violence, including degrading media images and themes (music, TV, movie, computer, gaming and marketing).

Family Violence 2010 Goal:

Reduce family violence in Shasta County.

Family Violence Prevention Measurements of Success:

1. By December 2010, decrease the rate of substantiated child abuse and neglect cases in Shasta County to 16 per 1,000 children under the age of 18. (Baseline: 19 per 1,000, Source: California Department of Social Services 2000)
2. By December 2010, reduce to 3% the percentage of adults who report actual or threatened violence by a current or former intimate partner in the last 12 months. (Baseline: 3.9%, Source: PRC2004)

Family Violence Prevention Action Steps:

1. Collaborate with the Domestic Violence Coordinating Council and other agencies to develop a community action plan to prevent family violence.
2. Increase the availability of community-based programs that emphasize age-appropriate problem solving and conflict resolution strategies for teen, parent-child, and intimate partner relationships through collaborative efforts.
3. Collaborate with local organizations to expand support for and education of parents at high risk for child abuse and neglect.
4. Educate consumers and providers about the unhealthy impact of violence, witnessing violence, and violent or degrading media images and themes.
5. Promote awareness of alternatives to violent and degrading media themes and images.
6. Support and encourage the development of community-based activities as alternatives to violent and degrading media exposure.
7. Establish a baseline measure regarding the amount of time children and youth spend in front of a screen.

Senior Health & Wellness

As we move into the new millennium, America is experiencing an increase in proportion of the population older than 65. The Census Bureau projects that by the year 2030, the United States will have an estimated 71 million people aged 65 and older and 19.5 million people aged 80 and older. This increase can be attributed to two main factors: a general decline in fertility, and public health and medical advances that have increased the average life span by approximately 20 years. In 2010, about 16% of Shasta County's population will be aged 65 years and older, a greater percentage than in the state as a whole. Older adults tend to experience chronic diseases disproportionately (80% of people ages 65 and older have at least one chronic condition and 50% have at least two). This, combined with the general overall increase in the elderly population, puts additional burdens on medical care and social systems.

Locally, approximately 13% of the senior population suffers from diabetes, and 26% suffer from heart disease. Only 63% received vaccinations against flu and pneumonia. In addition, 61% are moderately-to-highly limited in their daily activities because of arthritis pain. Among seniors during the year 2000, there were 516 hospitalizations and eight deaths due to fall-related injuries, four hospitalizations due to self-harm and six deaths from suicide. Seniors are at higher risk for depression and suicide due to chronic disease/pain, isolation, and loss of social status and life partners. Prevention strategies to address these issues include: increasing the number of people who get vaccinated for flu and pneumonia, conducting home safety checks, decreasing social isolation, increasing physical activity levels and healthy eating habits. Keeping these best practices in mind, the Department looked at local trends and chose to focus on the following strategies to address senior health and wellness in Shasta County. Prevention as it relates to influenza and pneumonia vaccination will be addressed in the Communicable Disease section of this plan.

Public Health's Approach to Senior Health & Wellness:

1. Work with community partners to address the issue of healthy eating among seniors.
2. Increase community capacity to provide physical activity opportunities for seniors that improve cardiovascular health, strength, balance, and flexibility.
3. Decrease falls and fall-related injuries.

Senior Health & Wellness 2010 Goal:
Reduce the incidence of injury and chronic disease among the senior population of Shasta County.



Prevention steps: increasing flu and pneumonia vaccinations, conducting home safety checks, decreasing social isolation, increasing physical activity levels and healthy eating habits.

Senior Health & Wellness Measurements of Success:

1. By December 2010, decrease the rate of fall related hospitalizations among persons aged 65 years and older to 1,480 per 100,000. (Baseline: 1,982 per 100,000, Source: EPIC 2000)
2. By December 2010, decrease the percentage of people aged 65 years and older who report having been diagnosed with diabetes to 15% or less. (Baseline: 19% Source: PRC2002).
3. By December 2010, increase the percentage of adults aged 65 years and older who eat five servings of fruits and vegetables per day to 40%. (Baseline: 34%, Source: PRC2002).
4. By December 2010, increase to 25% the proportion of adults aged 65 years and older who participate in moderate physical activity at least five times per week for at least 30 minutes per day. (Baseline: 16%, Source: PRC2004)

Senior Health & Wellness Action Steps:

1. Encourage fruit and vegetable consumption and promote community nutrition education for seniors.
2. Continue promoting the network of walking clubs and strength training classes for older adults throughout the county.
3. Provide physical activity curriculum and education for senior residential facilities.
4. Support and encourage healthcare providers to perform preventive health screenings and risk assessments for seniors, and make appropriate referrals.
5. Provide community education about fall prevention, and continue to support community-based programs focusing on home modification, physical activity promotion and medication use to reduce falls.
6. Promote physical activity opportunities in established and proposed senior housing developments, including senior appropriate community gardens and walking paths.

Bioterrorism/Emergency Preparedness

Bioterrorism (BT) can be defined as the intentional, threatened or alleged use of viruses, bacteria, fungi, and toxins (biological agents) to produce death or disease in humans, animals or plants. Historically, an attack with a biological agent would have been considered almost unthinkable. Today, however, the threat of bioterrorism is real and growing. There are at least 17 nations that are believed to have the capacity to develop and use offensive bioterrorism weapons. Intelligence sources also suggest that terrorist groups continue to pursue the resources and technology required to manufacture and employ biological weapons. This potential threat places huge demands upon the public health and medical communities to be able to recognize and respond appropriately should such an event occur.

In light of this threat, it is imperative that public health departments across the country be better prepared. Public health preparedness can be defined as having the systems, plans, and resources in place that enable local public health departments to address and handle community health emergencies. The nature of this preparedness is such that health departments will have enhanced systems in place that will allow them to respond not only to BT events, (for which they would have a significant role) but also to other community health emergencies including disease outbreaks and natural disasters.

Shasta County Public Health in accordance with the federal mandate from the Centers for Disease Control and Prevention (CDC) will focus its efforts on the following BT and Emergency preparedness strategies.

Public Health’s Approach to Bioterrorism/Emergency Preparedness:

1. Establish an all-hazard threat matrix for different disaster scenarios that highlights probabilities of threat occurrence and impact.
2. Collaborate with partners to develop community health emergency response plans and systems.
3. Increase the level of training and testing capacity of the public health laboratory to respond to a bioterrorist event.
4. Enhance the surveillance, reporting, tracking and investigation capacity for suspicious diseases throughout the public health and medical community.
5. Develop effective risk information and communication systems for both the public and key partners.
6. Sponsor emergency preparedness training and preparedness drills for public health staff and key partners.



Bioterrorism/Emergency Preparedness 2010 Goal:

Partner with local, state and federal agencies to have the functional systems, flexible plans and sufficient resources in place to prepare and protect the residents of Shasta County in the event of a community health emergency.

Public Health preparedness involves ongoing planning, development of response systems, training, and emergency drills.

Bioterrorism/Emergency Preparedness Measurements of Success:

1. By December 2010, Shasta County Public Health will establish and maintain a Joint Advisory Committee (JAC), that includes law enforcement and fire emergency managers, Red Cross, Emergency Medical Services (EMS), hospital, clinic and other healthcare representation, to advise on community health emergency planning and preparedness. (Baseline: no functioning JAC, 2003)
2. By December 2010, the Shasta County Public Health Laboratory will have an adequate number of trained staff to conduct rapid and specific confirmation laboratory testing appropriate for a reference laboratory. (Baseline: three microbiologists and one lab technician, 2003)
3. By December 2010, Shasta County Public Health will work with other public and private laboratories to establish an integrated community laboratory emergency response network. (Baseline: informal partnerships exist, 2003)
4. By December 2010, 90% of key community health emergency stakeholders will be able to rapidly receive and send community health information including alerts and critical health data through the California Health Alert Network (CAHAN). (Baseline: internal stakeholders identified, 2003).
5. By December 2010, Shasta County Public Health will develop and maintain a plan, trained staff, and resources needed to support the distribution of medical supplies to the public from the Strategic National Stockpile program. (Baseline: no plan, 2003)
6. By December 2010, Shasta County Public Health will collaborate with other community health emergency stakeholders to develop, deliver and evaluate six competency-based trainings and preparedness drills. (Baseline: two trainings completed [ricin and plague], 2003)
7. By December 2010, Shasta County Public Health will establish an all-hazard threat matrix to support the public health response in different disaster scenarios that highlights probabilities of threat occurrence and impact. (Baseline: no county-specific all hazards reference guide, 2003)

Bioterrorism/Emergency Preparedness Action Steps:

1. Conduct and/or participate in annual trainings, workshops, preparedness drills, and exercises for Public Health staff, local and regional partners, and first responders.
2. Assist in updating the county Emergency Operations Plan to include Public Health and BT response actions.
3. Continue to enhance communication and alert procedures for Public Health partners and the community.
4. Implement an electronic, web-based communicable disease reporting system when technology is available and feasible.
5. Continue to collaborate with hospitals, clinics, and EMS on bioterrorism capacity building activities.
6. Transform the Public Health Laboratory from a sentinel lab to a reference lab.
7. Maintain and update Strategic National Stockpile implementation plans for mass clinic operations.
8. Develop, train and drill a Pandemic Influenza Plan Annex for the Department Emergency Response Plan.



Healthy Eating

Over the past decade, there has been an increasing amount of evidence that directly links diet to coronary heart disease, certain cancers, stroke and type 2 diabetes. The marketing and nearly universal presence of high-fat, high-sugar, and high-calorie foods are prominent in our schools, neighborhoods, and worksites. The average American has a diet that is low in fruits, vegetables, and whole grains but is high in saturated fat and refined sugars. In fact, many individuals consume the equivalent of 20 teaspoons of sugar a day. With these current dietary habits, it is no wonder that we are currently facing an epidemic of obesity with 57% of American adults classified as obese or overweight. In Shasta County, only one-quarter of adults eat the recommended number of servings of fruit and vegetables per day, and 64% of adults are overweight or obese (PRC2002). According to the current Dietary Guidelines for Americans, a healthy diet is low in saturated fat and cholesterol, moderate in total fat, includes five or more servings of fruits and vegetables a day (5-A-Day campaign), incorporates a variety of whole grains, and is low in salt and sugar. Common prevention practices focus on developing good eating habits early in life starting with breastfeeding and continuing throughout adulthood. Keeping these best practices in mind, the department looked at local trends in eating habits and chose to focus on the following strategies to address healthy eating among Shasta County residents.

Public Health's Approach to Healthy Eating:

1. Design and implement a comprehensive campaign promoting increased fruit and vegetable consumption.
2. Research and support policies and food environmental changes that encourage schools and communities to offer more healthy food and beverage choices.
3. Work with community partners and families to address the issue of healthy eating among Shasta County children.
4. Assist new mothers in overcoming barriers to breastfeeding initiation and duration.



Healthy Eating 2010 Goal:

Improve healthy eating among residents of Shasta County.

Healthy Eating Measurements of Success:

1. By December 2010, increase the percentage of Shasta County residents who eat at least five servings of fruits and vegetables per day to 40% among adults, 60% among adolescents and 60% among children aged 2 to 11. (Baseline: 26% of adults, 58% of adolescents and 49% of children. Source: PRC2002 for adults, CHKS 2004-05 for adolescents and CHIS 2001 for children).
2. By December 2010, increase the percentage of all mothers living in Shasta County who breastfeed their babies at 6 months of age to 60% and the percentage of WIC clients who breastfeed their babies at 6 months of age to 30%. (Baseline: 58%, Source: 2001 SCPH/Mercy breastfeeding cohort study; 56%, Source: 2001 First 5 Shasta/Mayers breastfeeding cohort study; 27% of WIC clients, Source: WIC Extranet 2000).
3. By December 2010, increase the percentage of Shasta County 5th, 7th and 9th grade students who are within the healthy fitness zone, as defined by the Fitnessgram body composition component, to 80% or more. (Baseline: 74%, Source: CDE Fitnessgram Results 2002-03).



Our kids eat healthier if their school environment promotes healthier choices. Eliminating the sale of soda, high-fat and high-sugar junk foods and offering water, 100% juices, and healthy snacks to our kids will help this happen.

Healthy Eating Action Steps:

1. Implement a campaign through the Healthy Shasta Collaborative to increase fruit and vegetable consumption.
2. Work with community groups and organizations to increase access to and consumption of fruits and vegetables.
3. Educate policy makers, land use planners, health care providers, community leaders, grocery store and restaurant owners on policies and strategies that support healthy eating.
4. Work with schools to implement local policies and adopted legislation that improve nutrition on school campuses.
5. Work with schools to help develop healthier cafeteria and fundraising practices.
6. Increase utilization of food assistance programs, and ensure that nutrition education is part of such programs.
7. Increase early child nutrition education and BMI (Body Mass Index-measure of body fat) screening and intervention among child health providers, as well as referrals for appropriate follow-up.
8. Incorporate current scientific nutrition messages into appropriate department and community programs.
9. Support and collaborate with individuals, groups, and organizations that work to promote initiation and duration of breastfeeding.

10. Encourage physicians to promote breastfeeding and refer patients to breastfeeding support services.
11. Collaborate with area businesses and organizations to make breastfeeding-friendly environments for their employees and customers.
12. Support development and/or implementation of behavior modification programs for overweight and obesity focused on children and families.

Suicide Prevention

Suicide is the seventh leading cause of death and third leading cause of premature death before age 75 years in Shasta County. Depression and other mental disorders, substance abuse, physical or sexual abuse, and terminal/chronic physical illness are some of the main underlying conditions that lead to suicide attempts. Protective factors against depression and suicidal behavior include easy access to appropriate recognition and treatment of mental illness and substance abuse disorders, restriction of access to lethal means, sense of community, decreased social isolation, physical activity, contact with nature, and peaceful conflict resolution. Prevalence studies of depression in the general population reveal that about 15% of Shasta County adults are depressed at any given time and that 30% of Shasta County residents have experienced severe depression that lasted for two or more years at some time in their lives.



The rate of suicide attempts is greatest among teens and young adults, while the rate of suicide completion is greatest among seniors, especially men. In the month prior to their suicide, 75% of elderly victims had visited a health care provider. Males are four times more likely to die from suicide than females. Younger attempters and females tend to use less lethal means, such as ingestion of medications, while older attempters and males tend to use more lethal means such as firearms or hanging. Three-quarters of the firearm-related deaths in Shasta County are suicides. The suicide rate is higher in rural areas than urban areas, and this holds true for Shasta County, which has a rate of suicide twice that of the State of California. Because the causes of Shasta County's higher suicide rate are complex, the Department has developed a comprehensive strategy for suicide prevention in concert with other government agencies and community partners that will be implemented as resources become available.

Public Health's Approach to Suicide Prevention:

1. Increase primary care physician education and support regarding the recognition, treatment, and case management of mental illness profiles leading to suicide.
2. Increase identification and referral of persons at risk for suicide by youth- and senior-serving organizations and helping professionals.
3. Promote efforts to reduce access to lethal means and methods of self harm.
4. Improve and expand data collection systems for self-harm and suicide completion.

Suicide Prevention 2010 Goal:

Reduce the incidence of suicide attempts and suicide completions.

Suicide Prevention Measurements of Success:

1. By December 2010, decrease the rate of suicide attempts, defined as hospitalization for self-harm plus suicide completions, to 50 per 100,000. (Baseline: 73 per 100,000; EPIC2004)
2. By December 2010, decrease the rate of suicide completions to 12 per 100,000. (Baseline: 17 per 100,000; EPIC2004)
3. By December 2010, decrease the self-reported prevalence of major depression among adults to 12%. (Baseline: 15%, Source: PRC2004).
4. By December 2010, decrease the self-reported prevalence of a recent depressive episode among 7th, 9th and 11th grade students to 25%. (Baseline: 34%, Source: CHKS2004-05)
5. By December 2010, increase the rate of professional help seeking among adults with major depression to 50%. (Baseline: 43%, Source: PRC2004)

Suicide Prevention Action Steps:

1. Support and educate primary care clinicians and other providers regarding mental illness diagnoses (including in children and the elderly), substance abuse screening (including for alcohol) and protocols for effective treatment and follow-up.
2. Conduct a community awareness campaign to inform gun owners of the risk of firearm suicide, safe gun storage, and means of disposing unwanted firearms.
3. Work with community partners to provide temporary safe gun storage for families with a depressed loved one.
4. Investigate other methods of restricting access to lethal means, such as dispensing less than lethal amounts of medications at one time to patients with risk factors for or warning signs of depression or suicide.
5. Support the implementation of a high school-based suicide prevention program to train teens to identify signs of depression and refer depressed teens to a responsible adult.
6. Encourage the identification of isolated seniors with recent loss events and the provision of activities and companionship services.
7. Support maintenance and expansion of parks, trails, open space, green belts and other access to nature to enhance overall mental health and to help prevent depression, aggression, and mental stress.
8. Establish a comprehensive data collection system for attempted suicide and suicide completion, that may include data from the Coroner, law enforcement agencies, Mental Health, Public Health, hospitals and community health centers.

9. Work with the local law enforcement agencies to develop, refine, and implement standardized protocols for suicide death scene investigations and data collection.
10. Strengthen and broaden participation in the Suicide Prevention Coalition.
11. Advocate for same-day access to mental health care for all suicidal patients.
12. Encourage education of substance abuse counselors, geriatric counselors, county employees, first responders, members of the clergy, and other interested members of the public about suicide prevention.
13. Work with local agencies to develop a community awareness campaign to decrease the stigma associated with mental illness.

Oral health

The most common disease plaguing children in California, dental caries, is also the most preventable. Caused by bacterial infection in the mouth and often transmitted from new mothers, decay can occur as soon as the first tooth appears in an infant. Untreated infections lead to tooth decay that causes pain, inhibits learning, hinders proper speech development, contributes to poor self-image, and limits healthy eating. Approximately 50% of kindergartners and 70% of 3rd graders have experienced tooth decay.

Fortunately, dental disease is preventable. Fluoride stops or even reverses the decay process, keeping tooth enamel strong and solid. Studies have shown that water fluoridation – a safe, cost-effective measure that benefits all who receive it – can reduce the amount of decay in children’s teeth by as much as 60%. Fluoride supplementation is a more costly, but viable, alternative to community water fluoridation. Practicing good oral health habits such as healthy eating, decreasing sugar intake, brushing, flossing, and using fluoride toothpaste are also vital to preserving good oral health.

Unfortunately, lack of access to dental care can leave children at highest risk for dental disease without access to preventive and restorative services. Preventive services, such as periodic dental exams, sealants on molars, and fluoride varnish, can significantly decrease the incidence of dental caries in children. About one-third of low-income children have teeth with untreated decay compared to about one-fifth of higher income children. With these issues in mind, the Department has developed strategies that focus on improving the oral health of children.

Public Health’s Approach to Oral Health:

1. Ensure sufficient intake of fluoride to prevent tooth decay.
2. Collaborate with community partners to improve access to dental services for children.
3. Promote healthy eating, brushing, flossing, and periodic preventive dental visits to prevent gum and tooth disease.

**Oral Health 2010 Goal:**

Improve oral health among children.

Oral Health Measurements of Success:

1. By December 2010, increase to 60% the percentage of children enrolled in preschool who receive fluoride supplementation through their preschool site. (Baseline 38%; Source: Shasta Healthy Smiles Program 2006)
2. By December 2010, decrease to 45% the percentage of children aged 0 to 5 years who have never been to a dentist. (Baseline 54%; Source: F5S Parent Survey 2004)

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3. By December 2010, decrease to 5% the percentage of children aged less than 5 years who have dental problems. (Baseline 9%; Source: F55 Parent Survey 2004)
4. By December 2010, decrease the average number of decayed, missing or filled permanent teeth among 6th grade children to 1.2 per child. (Baseline 1.6 per child; Source: Healthy Smiles Survey 2001).

Oral Health Action Steps:

1. Encourage community water districts to fluoridate drinking water systems.
2. Explore the feasibility of expanding fluoride supplementation efforts to all preschool aged children enrolled in a preschool program.
3. Continue to provide fluoride supplementation to students in targeted K-6 schools.
4. Explore the feasibility of dispensing fluoride tablets to children through non-medical providers, such WIC.
5. Work with local medical providers to expand fluoride prescriptions to infants and young children, and to implement the application of fluoride varnishes in medical offices.
6. Educate parents and caregivers about the benefits of fluoride, less sugar intake, and the need for timely placement of sealants.
7. Educate medical providers on the importance of oral health for children and pregnant women, including how to prevent and recognize dental diseases, where to refer patients for preventive care or treatment, and the full-body implications of poor oral health such as pre-term birth, diabetes control, and heart disease.
8. Work with schools and early care providers to identify children with visual tooth decay and refer them for treatment.
9. Collaborate with the Oral Health Advisory Committee to improve access to dental health services for children.
10. Continue working with CHDP providers to assure the implementation of dental screenings and appropriate referrals for dental care, and follow up with CHDP families to assure access to dental care and follow through on referrals.
11. Develop and begin to implement community and provider education, with culturally appropriate messages aimed at increasing public understanding about the importance of good oral health practices, the transmissibility of caries, and the relationship of oral health to systemic health.
12. Incorporate appropriately tailored oral health education messages into existing county programs including, but not limited to, WIC, Healthy Beginnings, CHDP and the SMART Employer Outreach Program.

Alcohol and Other Drug Abuse Prevention

Alcohol and other drug abuse and associated problems are among society's most pervasive health and social concerns. Each year in the United States approximately 100,000 deaths are attributed to excessive alcohol consumption and 12,000 deaths are attributed to illicit drug use. The most recent national estimate (1998) of the economic cost of alcohol and other drug abuse was \$328 billion annually. In Shasta County during 2004, 50% of 7th graders reported they had been a passenger in a car driven by someone who had been drinking alcohol, 52% of 9th graders had consumed one full drink of alcohol, and 44% of 11th graders had used marijuana. Among local men aged 18-39 years, 30% reported engaging in binge drinking during the past month (5 or more drinks on one occasion). Shasta County exceeds California in these indicators, as well as in numerous other alcohol and other drug related behaviors.

Alcohol and other drug abuse results in numerous health and social consequences. Key health illnesses include cirrhosis and other liver disease, gastrointestinal problems such as pancreatitis and gastritis, numerous cancers, altered fetal and child brain development, motor vehicle crash and other injuries, alcoholism, and premature death. Social consequences include domestic violence, sexual assault, criminal behavior, unemployment and lost productivity, reliance on social safety nets, the need for drug and alcohol detoxification and treatment, and the stigma associated with alcohol and drug abuse.

Since alcohol and other drug abuse most often starts during adolescence, youth focused prevention is a best practice in public health. Considering these factors, the Department has developed strategies that primarily focus on preventing youth consumption of alcohol and marijuana, early drugs of abuse that may precede other substance use.

Public Health's Approach to Alcohol and Other Drug Abuse Prevention:

1. Collaborate with community partners to develop policies and practices that prevent youth consumption of alcohol and marijuana.
2. Promote alcohol and drug-free living as a community norm for youth.
3. Collaborate with community partners to promote alcohol and drug-free pregnancy.
4. Discourage binge drinking among teen and young adult males.



Alcohol and Other Drug Abuse Prevention 2010 Goal:

Decrease alcohol and other drug abuse.

Alcohol and Other Drug Abuse Prevention Measurements of Success:

1. By December 2010, decrease the percentage of 11th grade students who have used alcohol during the past 30 days to 35%. (Baseline: 40%, Source CHKS 2004)
2. By December 2010, decrease the percentage of 9th grade students who have ever consumed one full drink of alcohol to 45%. (Baseline: 52%, Source CHKS 2004)
3. By December 2010, decrease the percentage of 9th grade students who have ever used marijuana to 24%. (Baseline: 29%, Source CHKS 2004)
4. By December 2010, reduce the percentage of men aged 18-39 engaging in binge drinking (5 or more drinks on one occasion) during the past month to 25%. (Baseline: 30%, CHIS 2005)
5. By December 2010, increase reported abstinence from alcohol by pregnant women by 5%. (Baseline: TBD by Mother Infant Health Survey, 2007 Births)

Alcohol and Other Drug Abuse Prevention Action Steps:

1. After researching best practices, identify and implement two effective strategies, policies, or programs to prevent youth consumption of alcohol and/or marijuana, adult binge drinking, and alcohol use during pregnancy.
2. Work with community partners to promote and establish alcohol and drug-free family events and venues.
3. Work with youth to promote and establish positive recreational alternatives for area youth such as regular venues for alcohol and other drug-free events.
4. Establish a baseline measure regarding alcohol use during pregnancy.
5. Implement a substance abuse prevention program for pregnant women.
6. Partner with community-based organizations to expand youth alcohol and marijuana prevention activities and policy efforts.
7. Assess existing school alcohol and other drug use policies and work with at least one high school district to improve policies and/or practices.
8. Help schools implement new state health education standards for alcohol and other drugs.
9. Develop a community action plan with stakeholders after assessing community policy, practice, and norms related to alcohol consumption and the local alcohol distribution system.
10. Educate parents about youth sources of alcohol and support local efforts to prosecute and/or impose civil penalties on adults who provide alcohol to minors.

Next Steps

With the plan complete, it is time for action! Here are some steps we will take to see this plan accomplished by December 2010.

Communicate Health Priorities

- Distribute this plan (or the Executive Summary) to SCPH staff, community members, local leaders and elected officials, medical providers, media, and directors of grassroots/non-profit organizations.
- Post the plan on our website (www.shastapublichealth.net)
- Write brief articles about the plan for our newsletters for the community/medical providers, and other community publications.
- Share the health priorities, health outcome objectives, and potential activities with our partners and community members at meetings PH staff normally attend.
- Include these priority health outcome targets and activities whenever feasible in on-going staff reports to the Board of Supervisors.

Manage Public Health Resources

- Formulate our annual proposed budget requests based on these strategic priorities.
- Pursue grant funding in a targeted manner to help achieve these specific health outcomes.
- Guide staff enhancements, reductions, or reassignments to concentrate resources on the highest health priorities in our communities.
- Leverage limited resources with community partners in areas that will make the most health improvement.

Guide Staff

- Inform staff on the content of the strategic plan and tap their creativity and initiative in applying the plan to program areas.
- Develop program activities and scopes of work to focus fundamentally on the targeted health outcomes.
- Better coordinate staff from different programs working towards these high priority health outcome targets.

Partner with Communities to Improve Health

- Develop and renew contracts with community partners with these priorities in mind.
- Support community efforts to prevent disease and injury in key areas.
- Work with partners to change organizational practices that impact community health.
- Advocate together for healthier neighborhoods and environments that support improved health behavior choices.

Review and Monitor Plan

Every year, SCPH staff will report to the Public Health Advisory Board (PHAB) on progress toward objectives outlined in this plan. An evaluation document, *The People's Health*, will be produced periodically to assist in measuring success.

As with any long-term plan, current events sometimes alter priorities. SCPH staff completed a review of this plan with the PHAB in 2006 to assure that the strategic directions within the plan continued to be relevant for the current decade. In 2010, a new plan will be drawn up with targets to reach by 2020.