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AGENDA COVER MEMO

AGENDA DATE: April 27, 2011

TO: Board of County Commissioners

DEPARTMENT: Health and Human Services

PRESENTED BY: Rob Rockstroh

AGENDA ITEM TITLE: ORDER_____/ IN THE MATTER OF APPROVING THE LANE COUNTY PUBLIC HEALTH AUTHORITY PLAN FOR FY 2011-2012

I. MOTION

In The Matter Of Approving the Lane County Public Health Authority Plan for FY 2011-2012

II. AGENDA ITEM SUMMARY

ORS 431.375 through 431.385 establish county governments as the local public health authority and require local health authorities to submit an annual plan to the State Department of Human Services (DHS) on a mutually agreed upon date. ORS 431.410 establishes that the governing body of each county shall constitute an ex officio board of health.

III. BACKGROUND/IMPLICATIONS OF ACTION

A. BOARD ACTION AND OTHER HISTORY

The Board approved the FY 2010-2011 Public Health Authority Plan via BO 10-5-5-4. Last year's document was a "Comprehensive Plan" that covered three years until the Division's next triennial review. This year's document updates the triennial plan approved by the BCC in 2010.

The Comprehensive Plan submission follows a specific structure outlined by the State and provides an assessment of demographic and public health indicators for the County; a description of the delivery of core public health services; an action plan for the delivery of core public health services, a description of unmet needs and a checklist of compliance with the minimum public health standards.

B. POLICY ISSUES

The Authority Plan does not directly address the Public Health (PH) budget, in part because the annual funding amount provided by DHS to assist counties in addressing local public health needs is not released until after the due date of the authority plan.

ORS 431.416 states that the local Public Health Authority must carry out the following two duties:
1) Administer and enforce the rules of the local public health authority and DHS.
2) Assure activities necessary for the preservation of health or prevention of disease in the area under its jurisdiction, as provided in the annual plan of the authority, are performed through the following five basic services:

- Epidemiology and control of preventable diseases and disorders
- Parent and child health services, including family planning (delegate in Lane County to the Community Health Centers)
- Collection and reporting of health statistics
- Health information and referral services
- Environmental health services.

In addition, DHS (in conjunction with the Conference of Local Health Officials) has identified specific programs within the public health program elements that are required to satisfy the five statutory program elements and thus maintain the local Public Health Authority designation.

The list of Lane County's unmet needs addressed in the attached Authority Plan is substantial. Lane received an overall ranking of 18 out of 33 in the "county Health Rankings" publication by the University of Wisconsin. This year's authority plan refers to the following unmet needs:

- Frequency of WIC services in smaller communities thus leading to long-waiting time for clients
- Sexually transmitted disease prevention, education, and treatment services
- Ability to facilitate the community-based coalition to address the special needs of vulnerable populations during emergency hazards
- Ability to expand the coordination of chronic disease prevention to address diabetes, cancer and heart disease
- Sufficient resources to support nurse home visits for at-risk pregnant women and medically fragile infants and the ability to meet referral capacity for high-risk client referrals for services

C. BOARD GOALS

This Plan will assist Public Health in providing outstanding customer/constituent services.

Public Health moved into Chamelton Place in July, 2010. The new facility has enhanced Public Health's ability to provide quality services to the community.

PH benefits from the input, involvement, and hard work of a very active Public Health Advisory Committee (HAC) that meets monthly. The HAC does not limit itself to discussion, but actively researches a wide array of topics, improves community involvement in health-related issues and assists with the development of strategies. The HAC most recently met with the BCC on Tuesday, April 5, 2011 on the occasion of "Public Health Week."

Revenue Development – PH continues to seek resources to minimize reliance on general fund dollars. The successful Environmental Health on-line foodhandlers' training/testing program has generated sufficient revenue to permit Lane County to contract for the development of a new restaurant inspection application, now in the "beta" testing phase, with implementation slated for August, 2012. Public Health staff continue to aggressively pursue grant funding opportunities related to chronic disease prevention.

D. FINANCIAL AND/OR RESOURCE CONSIDERATIONS

The submission of the Authority Plan is not tied directly to the annual Public Health budget.

E. ANALYSIS

As stated previously and in accordance with ORS 431.416, in order to fulfill the duties of the local Public Health Authority and retain that designation, Lane County government must: administer and enforce the rules of the local Public Health Authority and DHS; and, assure activities necessary for the preservation of health or prevention of disease under its jurisdiction as provided in the comprehensive plan of the authority the basic five services contained in statute and rule: a) Epidemiology and control of preventable diseases and disorders; b) Parent and child health services including family planning clinics; c) Collection and reporting of health statistics; d) Health information and referral services; and e) Environmental health services.

The attached Authority Plan preserves a minimal function in each of the "core" areas mentioned above, as required by statute.

F. ALTERNATIVES/OPTIONS

1. To approve the FY 2011-12 Lane County Public Health Authority Plan and delegate authority to the County Administrator to sign the plan.

2. Not to approve the FY 2011-12 Lane County Public Health Authority Plan, as presented, and to give staff direction to revise certain elements of the Plan, delegating authority to the Acting County Administrator to ensure that the directed changes are made, prior to signing the revised Plan.

IV. TIMING/IMPLEMENTATION

Once approved by the Board of Commissioners and signed on their behalf by the Acting County Administrator, the Public Health Authority Plan will be transmitted to DHS. DHS, will review the Plan and approve or disapprove it. If Lane County's Plan is disapproved, DHS, in concert with the Conference of Local Health Officials (CLHO), will establish an appeals process, permitting Lane County an opportunity to obtain a hearing, to resolve any challenged elements.

V. RECOMMENDATION

Health & Human Services (H&HS) believes that the attached Public Health Authority Plan represents a best-faith effort on the part of Lane County to preserve local authority and requests that the Board authorize its signature by the Acting County Administrator, to permit for immediate submission to DHS. This recommendation reflects the conviction of H&HS senior staff that there is a great deal of inherent value in the retention of the local authority and that services delivered at the local level are more accountable, more responsive, more efficient and cost effective.

VI. FOLLOW-UP

Addressed under Item IV.

VII. ATTACHMENT

Board Order
Attachment A: Public Health Authority Plan and WIC Appendices

THE BOARD OF COUNTY COMMISSIONERS, LANE COUNTY, OREGON

RESOLUTION AND ORDER:	))	IN THE MATTER APPROVING THE LANE COUNTY PUBLIC HEALTH AUTHORITY PLAN FOR FY 2011-2012

WHEREAS, ORS 431.410 establishes that the Board of County Commissioners constitutes an ex officio board of health; and

WHEREAS, ORS 431.375 through 431.385 requires that the local public health authority to submit an annual plan to the Department of Human Services; and

WHEREAS, the annual submission of the Lane County Public Health Authority Plan to the State Department of Human Services must incorporate and translate the policy and direction of local public health services for the plan year; and

WHEREAS, the annual Health Authority Plan, herewith presented as Attachment A continues to reflect substantial unmet needs in Lane County, based upon the lack of funding resulting from factors such as reduced federal and state support, as well as reduced revenues as a direct result of the current recession;

WHEREAS, the County Commissioners are cognizant that difficult choices must be made to counterbalance the public's health needs in a time of fiscal constraint, but believe that Attachment A represents a good faith effort to provide services within the current fiscal context; and

WHEREAS, upon budget approval by the State of Oregon, funds will be allocated to Lane County to support the services described in the plan for FY 2011-2012;

NOW, THEREFORE, IT IS HEREBY RESOLVED AND ORDERED that the Board of County Commissioners approve the Lane County Public Health Authority Plan for FY 2011-2012, and that the Board of County Commissioners delegate authority to the Acting County Administrator to sign the Lane County Public Health Authority Plan and submit it to the State.

Effective this _____ day of April, 2011.

Faye Stewart, Chair
Lane County Board of Commissioners

APPROVED AS TO FORM
Date 4/14/11 Lane County
Office of Legal Counsel

LANE COUNTY PUBLIC HEALTH AUTHORITY
COMPREHENSIVE PLAN SUBMITTED MAY 2011
FOR FISCAL YEAR 2011/12

I. Executive Summary

The Annual Plan submitted for FY 2011-2012 for Lane County includes the following narrative sections: an assessment which provides demographic and public health indicators for Lane County; a description of the delivery of local public health services; an action plan for the delivery of core public health services; a description of unmet needs; and a checklist of compliance with the minimum standards. The local public health authority must assure activities necessary for the preservation of health or prevention of disease. Through the Intergovernmental Agreement with Oregon Health Authority, Lane County accepts the role of the local public health authority within the Board of County Commissioners. The Board delegates the responsibility for adhering to the requirements in the program elements of the agreement and assuring activities are accomplished to the Department of Health and Human Services, of which Lane County Public Health is a division.

The mission of Lane County Public Health is to preserve, protect and promote the health of all people in Lane County. During 2009, staff worked on updating our five year strategic plan. This process allowed us to think through what public health is, what we value in looking at the health of our communities, and what strategies we can put into place for the present and long term health effects. A tracking grid was also developed in 2009 and 2010 as a companion document to the plan in order for us to determine what we are accomplishing in relation to our objectives. Our Public Health Advisory Committee was involved in this process which enriched the product and understanding of what public health's role is in a community. Overarching goals in the plan are: 1. Service Integration (The community experiences accessible, aligned and adaptable public health services); 2. Communication (Public Health is valued and supported by the community); 3. Leadership (Public Health provides leadership in creating a Healthy Community); 4. Workforce Excellence (Maintain a competent public health workforce); 5. Quality Assurance and Improvement (Public Health continuously improves processes, programs and practices); and 6. Revenue Stability and Enhancement (Public Health has resources to achieve identified goals). Each of these goals are linked to the ten essential public health services that guide and inform the strategic directions of Lane County Public Health.

In July 2010, Lane County Public Health moved into the remodeled Charnelton Building. This is the first time all public health services are in one building, thereby facilitating easier access for our clients and staff to provide services. A significant amount of time was required for the remodeling, moving and settling in planning. The commitment from the Department Director of Management

Services, the Board of County Commissioners, the H&HS Department Director and Assistant Director made this change possible.

II. Assessment

Public Health Issues and Needs

Lane County spans an area of 4,620 square miles making it the fifth largest Oregon county by area. It stretches from the Pacific Ocean, over the coastal mountain range, across the southern Willamette Valley, to the crest of the Cascade Mountains. Although 90 percent of Lane County is forestland, Eugene and Springfield comprise the second largest urban area in Oregon. In addition, the county encompasses many smaller cities and rural communities.

The 2010 estimated population prepared by the Population Research Center of Portland State University for Lane County was 351,715, continuing it as the fourth largest Oregon County by population. The county has seen a steady growth over many years (2009: 347,690; 2008:345,880, 2007: 343,591, 2005: 335,180). US Census Bureau data and Portland State University, Population Research Center data provide a profile of Lane County's 2009 demographics:

- Percentage of persons 0-17 years old was 19.9% (state was 22.8%)
- Oregon Housing and Community Services (OHCS) Poverty Report 2010 (2007 status) shows 21% of the population living in poverty are children younger than 18.
- Percentage of persons 18-64 years was 64.6% (state was 63.6%)
- OHCS Poverty Report 2010 (2007 status) shows 71% of the population living in poverty are 18-64 year olds.
- Percentage of persons 65 years old and over was 14.5% (state was 13.5%)
- OHCS Poverty Report 2010 (2007 status) shows 8% of the population living in poverty are people 65 years and older.
- Lane County population reported in 2009 was 91.5% White with 3% Asian, 1.3% American Indian/Alaska Native, and 1.1% Black; .2 Native Hawaiian Islander and Other Pacific; additionally, 6.5% of the population identified as Hispanic or Latino origin.
- The level of educational achievement included 87.5% of the adult population as high school graduates and 25.5% of the population having a bachelor's degree or higher.
- The U.S. Census Bureau for 2008 notes the median household income as $43,614 compared $50,165 in Oregon. The same report notes 15.7 people live below the poverty level.
- The unemployment rate Lane County in December 2010 was 10.3 compared to the state 11.1. The rate in February 2010 was 11.4 compared to the state 10.5.

Additional indicators of health and wellbeing (data from Oregon Health Services as well as Lane County Public Health):

- Up to date immunization rate for 24-35 month olds in 2009 was 78%. The overall state rate was 65% for 2009. Lane County Public Health serves 1% of this age population while the private medical community provides the rest of the immunizations.
- Decrease increase in gonorrhea cases (in 2010 43 cases with an incident rate of 12.33/100,000; in 2009 139 cases with an incident rate of 39.5/100,000 population, in 2008 101 cases with an incident rate of 27.8/100,000 population) and an increase in chlamydia cases (in 2010 1281 cases with an incident rate of 367.52/100,000; in 2009 1,268 reported cases with an incident rate of 365.9/100,000 population, in 2008 1,052 cases with an incident rate of 340/100,000 population).
- Teen pregnancy rate for 10-17 year olds for 2010 was 5.7 compared to state at 7.1 per 1,000 teens 10-17.
- Teen pregnancy rate for 15-17 year olds for 2010 was 13.0 compared to state at 18.0 per 1,000 teens 15-17.
- 26% of Lane County adults are obese and another 35 are overweight.
- BRFSS 2006-2009 age-adjusted data shows 6.3% of Lane County adults have diabetes (6.8% statewide), 27.3% have high blood pressure (25.8% statewide), 33.6% have high blood cholesterol (33.0% statewide), 10.6% have asthma (9.7% statewide).
- 8% of 8th graders report smoking cigarettes compared to 9% in Oregon.
- 15% of 11th graders report smoking cigarettes compared to 16% in Oregon.
- 4% of 8th graders (males) report using smokeless tobacco compared to 5% in Oregon.
- 14% of 11th graders (males) report using smokeless tobacco compared to 14% in Oregon.
- 18% of adults report smoking cigarettes compared to 17% statewide.
- 23% of all deaths in one year in Lane County are due to tobacco use.
- 15% pregnant women report smoking cigarettes while pregnant, compared to 12% statewide.
- Fetal Infant Mortality rate 2001-2005 for Lane County was 8.25, down from 9.5 in 2000-2004. Oregon's overall rate was 8.0. Lane County's "Reference Group" rate decreased to 6.9. The most recent U.S. "Reference Group" rate is 5.8.
- In 2010, 49% of pregnant women in Lane County were served by WIC. Statewide it was 46.2%.
- In 2010, 13,548 women, infants and children were served in Lane County through the WIC program. Of those, 9,521 were infants and children under age 5 and 4,027 were pregnant, breastfeeding and postpartum women.
- In 2010, 5,439 families were served in WIC. Of those, 60.3% are working families. In 2009, 68% were working families. (A working family is defined as a household with at least one wage-earning family member.)
- In 2010, 93.8% WIC moms start out breastfeeding.

In 2010, there were 3,493 births to Lane County residents, down from 3,550 in 2009. Over the past ten years, the number of births has remained in the 3,500 to 3,700 per year range.

Births to teen moms as a percentage of total births generally declined over the past ten years. In 2000, the percentage of births to teen moms was 11.9%, and in 2010 the percentage was 7.4%.

In 2010, 63.3% of our Oregon Mothers Care (OMC) clients accessed prenatal care in their first trimester. This downward trend began in 2008 with the implementation of the requirement for a certified birth certificate for application for Oregon Health Plan (OHP) coverage. Prior to the birth certificate requirement, more women were able to access timely prenatal care. For example, 77.1% of OMC clients were able to access first trimester care in 2007.

Overall in Lane County, the percentage of infants born to mothers who had first trimester prenatal care has trended downward from a high of 80.2% in 2001 to 76.8% in 2010. The downturn in the economy and the increase in poverty and homelessness may contribute to decreased early access to care.

In 2010, percentage of births with low birth weight in Lane County was 6.4%. Over the past ten years the percent of low birth weight has gradually trended upward, with 5.7% of births with low birth weight in 2001. Low birth weight and preterm birth and the precursors of these outcomes are serious concerns for our community, particularly in light of Lane County's unacceptably high rate of fetal-infant mortality.

PRAMS (Pregnancy Risk Assessment Monitoring System) data for Lane County identifies several areas of concern with risk behaviors. Of the respondents, 24.9% admitted to binge drinking (5 or more drinks at one setting) in the three months before pregnancy. 26.1% admitted smoking in the three months before pregnancy. Alcohol and tobacco use are markers for illicit drug use. Alcohol, tobacco, and other drugs have a significant negative impact on birth outcomes, including birth weight and preterm birth. (Note: this data is based on the state's analysis of combined 2000-2004 PRAMS data. We do not have updated data at this time.)

Fetal-Infant Deaths

The incidence of fetal-infant mortality in a community is measured by the number of fetal and infant deaths per 1,000 live births and fetal deaths. The rate of fetal-infant mortality serves as a measure of a community's social and economic well-being as well as its health. Lane County's overall fetal-infant mortality rate has shown a decrease to 8.25 in the most recent data for Perinatal Periods of Risk 2001-2005. Community efforts to maintain and enhance this downward trend continue.

Lane County Public Health used the Perinatal Periods of Risk (PPOR) approach to investigate local fetal-infant mortality. PPOR is an evidence-based, internationally respected approach that looks at fetal and infant deaths in relation to weight at birth and age at death. The PPOR analysis revealed an unacceptably high rate of fetal-infant mortality in Lane County. Additionally, the PPOR results indicated that the problem was wide-spread and significant in all population groups regardless of economic, educational, geographic, age, and cultural status. Finally, the PPOR analysis revealed that the most excess deaths occurred in the post-neonatal period from one month to one year of age. The results of the PPOR analysis were shared with the broader community: and, from the resulting community concern, the Healthy Babies, Healthy Communities (HBHC) initiative was born.

Next steps in investigating Lane County's high rate of fetal-infant mortality was to initiate a prospective, individual case-finding approach that would help clarify causes of death, identify missed opportunities for effective interventions, and address policy challenges. Members of the HBHC initiative identified Fetal Infant Mortality Review (FIMR) as the strategy to use in case-finding reviews. FIMR was developed by the Maternal Child Health Bureau and the American College of Obstetricians and Gynecologists, and is a well-established and evidence-based approach. During the FIMR data gathering phase, information on the fetal or infant death is collected from medial records and a maternal home interview. This information is compiled and de-identified. It is then reviewed to identify critical community strengths and weaknesses, as well as unique health and social issues associated with poor outcomes. Recommendations for new policies, practices, and/or programs are developed and shared with the broader community. Identified issues are prioritized, and appropriate interventions are implemented.

After three years of the FIMR analysis, a number of common issues have been identified: a lack of pre-pregnancy health, health care, and reproductive planning; significant alcohol, tobacco, and other drug use immediately before and during pregnancy; a lack of understanding regarding the negative impact that the use of alcohol, tobacco, and other drugs has on fetal health and development; a lack of consistent and comprehensive prenatal risk screening and follow-up for psychosocial issues, alcohol, tobacco, and other drug use, domestic violence, and mental health issues; and significant unsafe infant sleep practices and confusion around co-sleeping.

Adequacy of Local Public Health Services

For FY 09/10, we were able to recoup much of the previous year's budget reductions and the staffing (one CD nurse was added, one Senior OA position, Public Health Officer position back to 26 hours per week, one Community Service Worker 2) due to a different budgeting process as well as a recognition for the need for a continued, sustainable communicable disease program and

public health infrastructure. The budget approved for FY 09/10 maintained the local public health authority, a value deeply held by the Board of County Commissioners. LCPH has developed, upon direction by the County Administrator, a budget that will make it possible for us to keep the local public health authority for FY 11/12, but one which does not address all the public health needs of our community. We are in the beginning stages of reviewing possible reduction scenarios as the many departments of the county project where they can make reductions. We have for FY 11/12 worked with the Community Health Centers of Lane County for a different billing strategy and have been able to reduce the need for MCH general funding by $175,000 while projecting that amount of funding via the billing process with the CHC. We attempted for FY 10/11 to create a new position within our Chronic Disease Prevention Team but it was not approved by the county budget committee. The need continues to fund such a position but we will not be pursuing the additional position this year due to the county's severe financial situation for FY 11/12. The Budget Committee has not begun their deliberations yet on the budget so we wait for further direction at both the state and federal levels for budget information. Reduction of funding in the special projects immunization will hamper our ability to provide the level of oversight and work our staff has done in the immunization program. There is also the looming concern that Lane County will not be receiving any timber funds in one year, which will greatly impact LCPH since we do receive funds to support our Communicable Disease, Maternal Child Health and WIC programs.

LCPH has a Public Health Supervisor on-call at all times (24/7/52). The on-call supervisor is reached through our answering service. This supervisor is able to call on other management and nursing staff resources as needed to manage the public health need Presently, due to the support of the county general fund, the communicable disease team is able to meet current expectations unless we have a large event or outbreak which would quickly overwhelm the local resources at public health. Through our effort with the H1N1, we have been able to seek volunteer nurses as well as extra help nurses to provide vaccinations, but to also have a cadre of nurses available should we need to call for additional assistance for any future outbreaks.

The Maternal Child Health Program receives many hundreds of referrals for Maternity Case Management for pregnant women and teens at risk of poor pregnancy and birth outcomes, Babies First! Targeted Case Management for infants at risk for developmental delays, and CaCoon Targeted Case Management for medically fragile infants and their families. Staffing limitations allows for only a fraction of those referred to receive nurse home visiting services.

The Maternal Child Health Nurse Supervisor brought together an internal departmental team and community partners to discuss the county's high fetal infant mortality rate. As part of the identification of best practices to reduce fetal-

infant mortality, the community coalition has determined that Public Health has inadequate capacity to provide long term, comprehensive nurse home visiting for families at risk of poor pregnancy and infancy outcomes. Research indicates that nurse home visiting needs to begin early in pregnancy and continue to age two. The high number of excess deaths between age 29 days and one year in Lane County indicate a great need for nurse home visiting (particularly for families with high psycho-social risks) to teach injury and SIDS prevention and child health and development needs. Because local hospitals and medical providers know that we are limited to six field nurses, they only refer infants with high medical/developmental risks. And, although we serve pregnant women with social risk factors through maternity case management, we are unable to continue serving their infants through Babies First unless there is a medical condition. The limited number of staff dictates that we offer services to families with the highest risks. This limitation means we are limiting access to other families with unmet needs.

Our WIC staff provides an exemplary level of service to the families they serve. The difficulty continues in keeping the caseload numbers up while developing streamlined schedules and processes in order to provide the nutrition education, assessment and voucher distribution needed. The myriad of required complexities within the WIC program continues to challenge us in serving the number of clients who qualify for the program. At this time, it is apparent that the need for WIC services has increased along with other service needs accompanying the economic downturn. The program is currently maintaining approximately 97% of assigned caseload.

The turnover rate in the WIC program remains a concern. Significant layoffs have continued in the Department of Health and Human Services in recent years, resulting in bumping of less senior staff, more staff turnover and increased need for training, thus delaying seeing clients. A significant amount of training time is required for WIC certifier positions. A major concern is that the WIC certifier positions require a specific skill set which is not compatible with some of the other county positions that are able to bump into these positions.

The Environmental Health program includes a staff of 11.6. Staff is presently able to tend to all the required inspections of the licensed facilities in the county. In addition, work continues on maintaining an electronic food handler testing program as well as walk in services for reading and testing for food handler cards. The Environmental Health Specialist staff has successfully built positive working relationships with the food industry as well as tourist and travel industry. The EH staff includes a Community Health Analyst 2 who works on preparedness and CD case investigations, especially those related to noro-virus, including outbreaks in nursing homes and large gatherings. Environmental Health program leads the state in the number of food manager training courses (Serve Save) provided in Lane County and has recently completed the first all

Spanish class. Environmental Health program continues an effective State Drinking Water Program.

Provision of Five Basic Services (ORS 431.416)

Communicable Disease

Epidemiology

Public Health communicable disease surveillance and reporting activities vary with the year. No one was sorry to see the H1N1 flu pandemic of 2009 and 2010 diminish. The annual flu season for the fall and winter of 2010 and early 2011 was more normal with scaled back surveillance indicating that the circulating influenza viruses were, largely, well matched to this year's trivalent vaccine and included H1N1 as a component of the seasonal vaccine. The ongoing challenge is to assure an appropriate level of understanding and respect for influenza, leading to appropriate prevention activities even during low incidence years.

Lane County Public Health (LCPH) recorded 930 reportable communicable diseases, not including sexually transmitted diseases (STD). Of this total number, 612 were newly reported cases of chronic hepatitis C. In addition there were 5 cases of newly acquired acute hepatitis C. This blood borne disease, which unlike hepatitis A & B, is not vaccine preventable, is taking on increased public health significance as people, infected years or even decades ago, age and their long undiagnosed infection progresses to serious liver disease. Also of concern is the new transmission of hepatitis C to individuals. With one year funding support from the state, LCPH has been participating in an enhanced surveillance project for those individuals between ages 15 and 30 with newly reported hepatitis C. This subset of individuals can be presumed to have acquired the infection relatively recently and to be at increased risk of transmitting it to others. Enhanced surveillance is aimed at detecting transmission patterns among these individuals and providing education and prevention counseling.

Another communicable disease of note is the continued presence of cases of pertussis, or Whooping Cough, in our community as well as in outbreaks in other parts of the country. LCPH received 52 reports of pertussis in 2010. This undoubtedly under represents the burden of disease in Lane County. It is significant that pertussis is a vaccine preventable disease that carries significant risk to young children and individuals with certain chronic illnesses and immune disorders. Some of these individuals cannot be immunized, or do not mount an effective immune response when vaccinated. It is important the community around them maintain a high level of vaccination to reduce the chance that the most vulnerable individuals are protected.

LCPH completed the transition to the state ORPHEUS database for communicable disease reporting. With strict confidentiality protections in place,

the database has improved the cooperative reporting between the county and the state as well as with surrounding counties in select situations.

Tuberculosis

Lane County continues to be a low incidence area for active tuberculosis. The official count of verified tuberculosis cases for 2010 was 8 with an incidence of 2.3 cases per 100,000 population. Following a through investigation to identify and prevent related cases, each case of active disease requires 6 to 12 months of intensive, multidisciplinary case management led by LCPH communicable disease nurses in conjunction with our health officer, support staff, state tuberculosis control program staff, private medical providers, and other individuals and organizations in the community related to the case. Tuberculosis cases in 2010 were both foreign born and home grown, with 2 related cases stemming from the long ago illness of a deceased relative in another state. All of the individuals with tuberculosis who were in the working age group were employed. None of the cases in 2010 were homeless. LCPH continues to provide twice yearly inspection of the UV lights that were installed at the Eugene Mission.

STD Control Measures

LCPH has transitioned to the statewide ORPHEUS database for STD reporting. This is facilitating confidential communication and morbidity reporting with the state as well as with other counties. In addition, database security and access has improved communication between the LCPH staff and the off site state Disease Information Specialist who investigates high risk STD cases such as gonorrhea, chlamydia in pregnant women, and syphilis.

In 2010, LCPH received 1,281reports of chlamydia with an incidence of 367 reported cases per 100,000 population. There were 43 reports of gonorrhea with an incidence of 12/100,000. There were 2 reports of syphilis. Thus Chlamydia continues to be reported in historically high numbers.

In 2010 LCPH hired and trained a new communicable disease nurse, increasing our capacity to provided STD appointments. With efficiencies gained in the move from the Health Annex to the new facility in the Charnelton Building, LCPH has been able to more readily serve our clients referred for or seeking STD services. Also, in response to the move to a new facility and to address points in the 2010 Triennial Review, LCPH has written a new lab manual. The manual is focused on specific policies and procedures for nurses providing both the STD examination and treatment client services, as well as attending to lab sample collection and packaging in accordance with state and OSHA requirements. With the hiring of a new Health Officer, the Communicable Disease STD staff is able to address gaps in laboratory expertise that occurred when the lab technologist position was eliminated.

Immunizations

In calendar year 2010, LCPH directly provided 3,443 non-flu immunizations. Our delegate clinics provided 7,790 in the same timeframe. We are finding that the new LCPH facility is more efficient for the provision of clinical services, as well are much more comfortable and welcoming for clients.

In 2010, LCPH prepared and trained to transition to the new state IIS Alert Immunization registry. As the data registry enrolls new providers, opportunities to assure that children's immunization records are accurate and up-to-date even as families move from one location and provider to another.

LCPH reviewed 53,054 school immunization records for completeness for the 2010/2011 school year for all children in pubic and private schools, and in preschools and certified day care facilities. We worked with 158 school and 152 children's' facilities to address omissions in immunization records. On February 2nd, 2011, school exclusion letters were issued for 2,766 students. Of these, 328 students were excluded from school until immunization records were documented as being in compliance with state requirements. LCPH, therefore, achieved over 99% of our 100% target for completed school immunization exclusion day on February 17th.

The Religious Exemption (RE) from required school immunizations increased across Lane County to 5.7% in 2010 from 5.43% in 2009. This year, for the first time, the report breaks down the exemption by vaccine antigen as well as by individual school. RE rates from one school or from one area of the county to the next vary widely and LCPH is in the middle of a 3 year process to attend to the issue in schools with excess REs and large numbers of children. Efforts last year focused on surveying and gathering information from parents and schools regarding attitudes, education, and access to immunization information. Efforts this year will focus on addressing the information gaps among staff at these schools and childcare facilities.

HIV

The LCPH HIV Program continues to focus program resources and efforts on testing and prevention services to populations at greatest risk for disease. This emphasis is reflected in both our in-house and outreach efforts at LCPH and in our support and collaboration with our subcontracted agency, HIV Alliance. As funding at both the state and local level continue to decrease, we continue to strive to increase accessibility to members of these populations.

Coinciding with the move to a new public health facility in July of 2010, provision of 10 pack needle exchange services was transitioned to our subcontracted partner at HIV Alliance.

HIV Counseling Testing and Referral Services (CTRS) continue to be provided by appointment and, when possible, for client drop-in. In 2010, LCPH provided these services in-house and also at Willamette Family Treatment Center (WFTC). Outreach and testing was also provided at Buckley Detox & Sobering Center. Wednesday afternoons remain a reserved and promoted time for testing men who have sex with men (MSM) at LCPH. In addition, the LCPH HIV counseling and testing staff member continue to collaborate with HIV Alliance to provide HIV testing at special events such as Project Homeless Connect and at the University of Oregon during times dedicated to awareness and services to African American/Black and Latino communities.

LCPH has a Performance Measure to focus at least 65% of our HIV testing to populations at increased risk of HIV including MSM, injection drug users (IDU), and sex partners of people in these populations. In 2010 LCPH and its subcontracted partner together exceeded that goal every month and provided a total of 1,032 HIV tests. LCPH itself provided 410 of these HIV tests, exceeding our goal of 400. Program plans for HIV testing in fiscal year 2012 call for LCPH to provide 445 HIV tests. HIV Alliance will continue to have testing capacity. The estimated number of HIV tests that HIV Alliance will perform during the same time frame is 590.

LCPH continues to actively support and participate in the Lane County Harm Reduction Coalition (LCHRC) which consists of private and public partners with the purpose of reducing the impact of injection drug use and other substance abuse on public safety, community health, and individual health.

Parent and Child Health Services

The Prenatal (PN) program helps low-income pregnant women establish health insurance coverage with OHP and helps ensure the initiation of prenatal care with local medical care providers. Prenatal access works in collaboration with hospitals and private providers to increase access to early prenatal care; and works in collaboration with Maternal Child Health nurses and WIC staff to provide a system of services for vulnerable families. Approximately 392 low income pregnant women were served in 2010. Additionally, the percentage of women who were able to access first trimester prenatal care was lower as a result of the requirement for a certified birth certificate prior to establishing OHP eligibility and early prenatal care.

The Maternal Child Health (MCH) program provides nurse home visiting, education, support, and referral to appropriate medical and developmental services for families at risk of poor pregnancy, birth, or childhood outcomes. MCH services are provided countywide by a limited number of public health nurses (5.8 FTE). Pregnant women, infants, and young children at highest risk and greatest need are given priority when decisions about which families to serve have to be made. In 2010 MCH nurses provided home visiting for 748 unduplicated clients. Of these, 370 received maternity case management, 321

received Babies First!, and 57 received CaCoon services. The Maternity Case Management program provides nurse home visiting services for high-risk pregnant women; and, helps assure access to and effective utilization of appropriate health, social, nutritional, and other services during the perinatal period. The Babies First! program provides assessment and early identification of infants and young children at risk of developmental delays or other health related conditions. The CaCoon program provides services for infants and children, who are medically fragile or who have special health or developmental needs, by helping their families become as independent as possible in caring for the child and by helping families access appropriate resources and services. Of particular concern for the MCH program is that although we receive 100-200 high risk referrals per month, we are able to serve only those at highest risk.

As of July 1, 2006, the Family Planning (FP) program was moved from the Public Health Division of the Lane County Department of Health and Human Services to the Human Services Commission, also within the Lane County Department of Health and Human Services. The FP clinic is now within the federally qualified health center, also known as Community Health Centers of Lane County. Goals for the FY 11/12 year for the Family Planning Program which fit within the Title X requirements are: 1. To promote awareness and access to emergency contraception among Oregonians at risk for unintended pregnancy. 2) To direct services to address disparities among Oregon's high priority and underserved populations.

Collection and Reporting of Health Statistics

Lane County Public Health provides statistical information to Oregon Health Authority/Public Health Services on a regular basis – including CD reporting on each case investigation; blood work sent to the state lab; inspections conducted by the environmental health staff; HIV program reporting requirements; IRIS, the WIC data system; the immunization data system ALERT; and ORCHIDS MDE for women and children's data.

Health Information and Referral Services

Lane County Department of Health and Human Services and Lane County Public Health (LCPH) publicize location, phone numbers and listing of services. We have developed a web site for the department that has specific information regarding each program within the department. We also have a strong working relationship with the county Public Information Officer (PIO) who assists in disseminating up-to-date information regarding any public health issue in which the community may be interested. The PIO has a section on the general county website for public health issues, such as smallpox, H1N1 and West Nile Virus, providing easy access for citizens. LCPH has available brochures, the mission statement, and a handout with clinic services, times and locations.

Environmental Health Services

The Environmental Health (EH) program includes the inspections of licensed facilities, primarily food service facilities. The following are the types and numbers of facilities licensed and inspected by the EH staff in 2010: full service and limited service food facility (937), bed and breakfast (13), mobile units (152), commissaries and warehouses (37), temporary restaurants (1075), pools/spas (266), traveler's accommodations (116), RV parks (73), and organizational camps (12), for a total of 2,681. The total in 2010 was 2,554 was 2,464. In addition to license facility inspections, EH staff completed 160 daycare inspections and 244 school/summer food program and miscellaneous kitchen inspections for jails, fratemities, group homes, etc. The EH and CD teams work closely together as needed to ensure safe food and tourist accommodations. In 2010, the following are some of the violations found upon general inspections: improper holding temperatures (471), contaminated equipment (360), and poor personal hygiene (70). Food borne illness continues to be a concern when food is not prepared, served or stored in a safe and sanitary manner. Ongoing monitoring of facilities and training of food service personnel can prevent food borne illness. The EH food handler testing program issued 67,784 food handler cards in Lane County and counties across the state through agreements. Of that total, 1,403 were issued in-house. In addition to the above services, EH also provides Drinking Water Program surveillance to 311 public water systems in Lane County. Approximately 52-55 water system surveys are conducted yearly throughout Lane County.

Adequacy of Other Services

Chronic Disease Prevention

Tobacco use continues to be the leading cause of preventable death in the U.S., Oregon and Lane County. Twenty-two percent of annual deaths in Lane County are attributed to tobacco use. Through minimal state funding, the Lane County Tobacco Prevention and Education Program (TPEP) continues to reduce tobacco-related illness and death by countering pro-tobacco influences, promoting tobacco cessation resources, and eliminating and reducing people's exposure to secondhand smoke through the creation and enforcement of smoke-free environments. (See Tobacco Prevention Program objectives under Action Plan section.)

Lack of physical activity and poor nutrition are the second leading cause of death in Lane County. Twenty-six percent of Lane County adults are obese (70,663) and another 35% (95,122) are overweight. Health consequences of obesity include coronary heart disease, type 2 diabetes, cancers (endometrial, breast, and colon), hypertension, Dyslipidemia (for example, high total cholesterol or high levels of triglycerides), stroke, liver and gallbladder disease, sleep apnea and respiratory problems, osteoarthritis (a degeneration of cartilage and its underlying bone within a joint) and gynecological problems (abnormal menses, infertility). Obesity is also financially costly for Oregon. A study commissioned by

the Northwest Health Foundation found that 34 percent of the increase in Oregon's health expenditures between 1998 and 2005 could be attributed to the rising obesity prevalence. (See Healthy Communities Program objectives under Action Plan section.)

Primary Health Care

In regards to primary health care a division within the Lane County Department of Health and Human Services was established – Community Health Centers (CHC) of Lane County. The central office is called Riverstone, located in Springfield. A second location for the clinic has just been established in the "Charnelton" Building, the building that all public health services are now located (as of July 2010). Having a primary care clinic in the same building as a public health service has been helpful to the people we serve and provides for continued coordination of services between the two divisions. The CHC provides family planning, pediatrics, internal medicine, family practice and now prenatal care.

Medical Examiner

The Deputy Medical Examiner program was moved out of the Lane County Department of Health and Human Services in 2002 to the District Attorney's Office. This seemed to be a more prudent link for the work that is done with the enforcement activities. The Deputy Medical Examiner continues to work with LCPH and the Department in regards to SIDS and those deaths of significant public health concern (e.g. heroin overdoses, adolescent suicides, injuries).

Emergency Preparedness

Preparedness for disasters, both natural and man-made, is a public health priority. Our Public Health Emergency Preparedness ("PHEP Program") develops and maintains the capacity of the department to rapidly mount an effective response to an emergency and to prevent, investigate, report and respond to outbreaks or the spread of communicable diseases. The PHEP program addresses public health mitigation, preparedness, and response and recovery phases of emergency response through plan development, training and exercise, and plan revision. The program also galvanizes the community to tackle local preparedness needs, and specifically focuses planning for the needs of the community's most vulnerable populations. The program is actively monitored to assure the attainment of professional standards and state/federal guidelines and to evaluate the program's success.

For FY 2011-12, the following objectives have been identified for the PHEP Program:

1. Maintain and update the Lane County Emergency Operations Plan describing the functions, capabilities and procedures necessary to mitigate, respond and recover from a local emergency.

2. In conjunction with hospital and health care preparedness planning underway in the local healthcare community, actively support the development of medical surge plans.
3. Update and implement the Lane County Public Health exercise and training program, including providing regular training opportunities and at least two exercises that increase in complexity and adhere to Homeland Security Exercise and Evaluation Program (HSEEP) guidelines.
4. Document attainment of national standards and achieve recognition through the national Project Public Health Ready program.
5. Provide technical support to the Lane County Vulnerable Populations Emergency Preparedness Coalition and assist with actions identified within the coalition's work plan.
6. Share program accomplishments and lessons learned by presenting at professional conferences.

III. Action Plan

Communicable Disease Program

- **Current condition or problem:**
  1. TB case management and DOT for all active TB cases as defined in Program Element 03 of IGA with DHS/Oregon Health Authority.
  2. Continued elevated rates of chlamydia.
  3. Working with state to complete ALERT IIS transition.
  4. Countywide immune rates for 24-35 month olds (4-3-1; 3-3-1) was just 60.2% in 2009 – the last year that information is available. Statewide the percentage is 65.5%.
  5. LCPH clinic up-to-date immunization rate for the same antigens in this population is 78%.
  6. Focus on completion of required staff preparedness training.
  7. Continued immunization delegate support for 9 clinics.
  8. High religious exemption rates for immunizations in certain populations. (See Immunization Action Report)

- **TB Control Measures:**

  Goals:
  1. Prevention of TB outbreaks at homeless shelter.
  2. Provide culturally competent TB case management for all clients.
  3. Meet state performance measures in Program Element 03.
  4. At least 90% of individuals within LPHA's jurisdiction with newly diagnosed TB, who are identified by or reported to LPHA and for whom therapy for one year or less is indicated, complete therapy within 12 months of the identification or report.
  5. Contacts are identified for at least 90% of newly reported or identified sputum AFB-smear positive TB cases within LPHA's jurisdiction.
  6. At least 95% of Contacts to reported or identified sputum AFB-smear positive TB cases within LPHA's jurisdiction are evaluated for infection and disease.
  7. At least 85% of infected Contacts to reported or identified sputum AFB-smear positive TB cases within LPHA's jurisdiction who are started on treatment for latent TB infection will complete therapy.
  8. Assure TB case management staff remain current with standards of care.
  9. Assure health and safety of staff when providing TB case management care.

  Activities:
  1. Twice yearly inspection of the ultra-violet light system (system was installed Fall of 2003.)

2. Assure availability of professional staff with appropriate language skills. Staff will meet required diversity trainings. Individualized assessment of client needs include cultural appropriateness of services.
3. Maintain up to date reporting to state to show required performance measures for Program Element 03 are being met.
4. CD nursing staff and Public Health Officer participate in regular state and in-house TB case management reviews.
5. Participate in state webinars as offered.
6. Annual review of the LCPH Respiratory Protection Plan and fit testing of designated staff.

Evaluation:

1. Biannual evaluation of UV lights will show homeless shelter staff following procedures for light maintenance.
2. Continue surveillance and monitoring of TB cases as noted in Program Element 03 of IGA with DHS/Oregon Health Authority.
3. Triennial program review with state and local staff completed September 2010.

- **STD Control Measures**:

Goals:

1. Prevent and control spread of STD's in Lane County
2. Meet program requirements in Program Element 10.
3. Increase direct STD services to clients.
4. Address STD investigations locally.
5. Clarify nursing standards for scope of practice in STD clinic.

Activities:

1. Annual review of STD protocols to ensure the protocols are in line with CDC and state guidelines.
2. Ongoing CD team review of LCPH STD clinic process.
3. Update STD nurse orientation and training resources
4. Increase LCPH capacity to provide STD case management.
5. Maintain STD surveillance and reporting process using established community links, local trained staff, and the ORPHEUS data system.
6. Target outreach and clinic availability, in conjunction with state program, to clients at high risk for STD's.
7. Work with state to optimize community resources in provision of services.
8. Evaluate funding sources to support county DIS position.

Evaluation:

1. Staff will enter and monitor program output and outcomes data as part of the countywide performance measure tracking. STD performance measures provide data on reportable STD incidence rates.
2. Updated STD nurse orientation materials will be assessed by current, experienced CD nurse staff and by trainee for training effectiveness .
3. Any new STD nurse will achieve initial proficiency in STD exams and treatment and case management within 6 months of hire.
4. LCPH STD reporting process will meet state standard for timeliness and completion.
5. LCPH will continue collaboration with state STD program, the Community Health Centers of Lane County, and Planned Parenthood to assure access to STD services during both normal public health activity levels and during times of surge efforts on other communicable disease work.

- **Continued integration and training of applicable preparedness activities and staff with Communicable Disease (CD) program.**

Goals:

1. CD team members will understand and maintain currency of preparedness training.
2. Develop and maintain surge capacity nurse training for CD and preparedness.
   a. Expand, organize and document CD team preparedness trainings.
   b. CD team will participate in drafting, reviewing and exercising preparedness plans.
   c. CD team members will meet trainings required as outlined in preparedness program elements of IGA with DHS/Oregon Health Authority.

Activities:

1. CD/Preparedness staff will participate in monthly preparedness staff meetings.
2. Complete mandatory trainings according to the Public Health Training Plan for staff positions.
3. Continue to involve CD staff in appropriate preparedness planning.
4. Participate in preparedness exercises and drills.

Evaluation:

1. Staff will enter and monitor program output and outcome data as part of the countywide performance measure tracking.
2. At least annually, training records will be examined for progress and achievement of standards.

3. Evaluation of exercises, events will be done in a "Hot Wash" and After Action Reports with the CD team.
4. Assure CD staff training records are complete.

- Continue to focus on increasing overall immunization rates of 24-35 months olds (served by LCPH).

Goals:

1. Maintain performance measures we have met, including those we continue to work on.
2. Continue to assure current and accurate data on ALERT IIS.
3. Provider information/resources that addresses provider concerns and parent hesitancies regarding vaccines.
4. LPHA shall improve the 4:3:1:3:3:1 immunization series coverage rate by one (1) percentage point each year and/or maintain a rate of > 90% ($ DTaP, 3 IPV, 1 MMR, 3 Hep B, 3 Hib,1 Varicella). (PE 43 of IGA)
5. LPHA shall reduce their Missed Shot rate by one (1) percentage point each year and/or maintain the rate of < 10%. (PE 43 of IGA). While this remains a state and county goal, LCPH's unique immunization clinic population includes many parents with vaccine hesitancy. Staff continues to work to provide information and education to these families about each recommended and school required immunization. None-the-less, we do provide all the recommended immunizations that the parent will accept, even if this means that we have missed shots recorded.
6. 95% of all state-supplied vaccines shall be coded correctly per age-eligibility guidelines (PE 43 of IGA).
7. 80% of infants in LPHA's Service Area exposed to perinatal hepatitis B shall be immunized with the 3-dose hepatitis B series by 15 months of age. (PE 43 of IGA).
8. 80% of all vaccine administration data shall be data entered within 14 days of administration. (PE 43 of IGA)

Activities:

1. Use reports from AFIX to clarify areas of need.
2. Evaluate specific areas, i.e. missed dose rate in AFIX report and obtain name list from state immunization staff to facilitate record evaluation.
3. Review AFIX report with staff and determine if there are areas where staff training/update would be beneficial.
4. Monthly evaluation of code report for accuracy.
5. Systematic monitoring and follow-up for perinatal hepatitis B.
6. Data entry of all immunizations given within 14 days of administration.
7. LCPH partner with state in discussions to provide information/resources to providers regarding vaccine hesitancies.

Evaluation:

1. Complete review of AFIX report annually for missed doses and up to date information compared to goal.
2. Discussion of AFIX findings at Communicable Disease Team meeting annually.
3. Review state evaluation of perinatal hepatitis B and address discrepancies.
4. Compare monthly report of vaccine coding and compare to goal in contract performance measures.
5. Provider assessment regarding concerns regarding children's vaccinations.

HIV Program

Current condition or problem:

1. The population in Lane County includes residents at high-risk of acquiring and spreading HIV infection.
2. Lane County Public Health (LCPH) has a well-established HIV counseling and testing program which includes outreach and education to members of groups at increased risk for HIV.
3. LCPH maintains a contractual relationship with a community-based organization (HIV Alliance) for further provision of services to clients with HIV and those at risk.
4. LCPH is an active participant in Lane County Harm Reduction Coalition.

Goals:

1. Prevent spread of HIV Disease.
2. Increase rates of testing in populations high-risk for HIV infection.
3. Link individuals at risk with other LCPH prevention services.
4. Provide counseling, testing information and referral services to individuals within targeted high-risk groups.
5. Reduce community exposure and reuse of needles in IDU population (intravenous drug user).

Activities:

1. Provide confidential and anonymous HIV counseling and testing per DHS/Oregon Health Authority contract per minimum service requirements.
2. Provide community outreach to MSM and injecting drug populations to encourage HIV counseling and testing, and education as to how to prevent the transmission of the HIV virus.
3. Through participation on the Harm Reduction Coalition, LCPH will continue to provide leadership and partnership with other organizations to support programs and events that help prevent the spread of HIV infection.

4. Continue to support subcontracted agency on their best practice programs, including counseling and testing and needle exchange activities.
5. Direct provision of LCPH services such as STD exams and treatment and/or referrals such as HIV case management per IGA with DHS/Oregon Health Authority.

Evaluation:

1. HIV program staff will maintain data as required by DHS/Oregon Health Authority and CDC, per the intergovernmental agreement (IGA).
2. Staff will enter and monitor program output and outcome data as part of countywide performance measure tracking.
3. Ongoing coordination and contract monitoring regarding HIV prevention services with subcontracted agency.
4. We will meet our performance measure goal of 65% or greater testing for high-risk populations.

Collection and Reporting of Health Statistics

Current condition or problem:

As of April 1, 2007 the registrar for birth and death records/certificates and the Vital Records staff moved to the Public Health Division. It was previously housed in the Department of Health and Human Services Administrative Office. Public Health programs do data entry for individual programs – WIC, Maternal Child Health, Family Planning, Immunizations. Having the Vital Records program housed with public health has proven valuable especially as we have established the Fetal Infant Mortality Review team and have had statistics available for the team.

Goal:

Maintain current data entry in order that all statistics are up to date and provided to the state in timely manner.

Activities:

1. 100% of death certificates submitted by Lane County Dept. H&HS are first reviewed by the local registrar for accuracy and completeness per Vital Records office procedures. (Per change in policy directive from state, birth certificates are no longer reviewed.)
2. All vital records and all accompanying documents are maintained in a confidential and secure manner.
3. Certified copies of registered birth and death certificates are issued immediately upon request at the walk-in counter or optimally within two business days of receipt by mail when all required documentation is available from the state. Staff are available from 8:00 am to 11:30 am and 1:00 to 4:30 pm five days per week.

4. Public Health program staff will do data entry in timely manner to ensure accuracy of records and ability to bill for services (e.g. Babies First, Maternity Case Management).
5. Staff continue to answer many inquiries regarding obtaining birth certificates six months of age and older from the state vital records office.

Evaluation:

1. Public Health staff will continue to verify the accuracy and completeness of death certificates.
2. Public Health staff will continue to monitor that mailed requests for certificates are issued within two working days of request when required documentation is available from the state.
3. Public Health staff will monitor data entry and ensure that entries are done in a timely manner and that revenue is received on a monthly basis due to the data entry.

Environmental Health Program

Current condition or problem:

1. There are more than 2,500 facilities in Lane County providing eating, living and recreational accommodations for public use.
2. The EH and CD teams of LCPH collaborate regarding food borne investigations, animal bites and more currently with increased incidence of noro-virus in nursing care facilities.
3. The EH team is actively involved in preparedness training and interagency exercises. One EHS has extensive Hazmat Audit and Response experience. Two EHS are being trained as emergency preparedness Public Information Officers.
4. Two new EHS personnel have attended the latest state orientation meeting for new EHS personnel.
5. An internship program has been established in the EH program with primary duties of strengthening our education program to Food Service Industry at the Management and Supervisory levels.
6. Three EHS personnel have been certified as a Serve Safe Trainer.
7. Two EHS personnel have attained national training in Pool Operator Certification.
8. The EH program has recently expanded to include inspection of State Drinking Water systems. Lane County has 311 public water systems that require routine sanitary surveys.
9. The Preparedness and Environmental Health teams are developing an Environmental Health Surety Plan.

Goals:

1. Ensure licensed facilities in Lane County are free from communicable diseases and health hazards.

2. Continue to focus attention on Food Service Management and Supervisory personnel training.
3 Continue to work on FDA Program Standards.
4. Update electronic inspection program to a web-based platform in cooperation with the State Environmental Health Program.
5. Ensure all state drinking water systems in Lane County are free from communicable diseases and health hazards as noted in the State Drinking Water (SDW) IGA.
6. Conduct inspections of licensed facilities in a timely manner as required in the State Food Program (SFP) IGA.
7. Coordinate food-borne investigations with CD team.
8. Continue follow-up on citizen complaints in a timely manner as noted in the SFP IGA.
9. Provide food handler and food facility management education, testing and licensing as required in the SFD IGA.
10. Develop nursing home training regarding prevention of noro-virus.
11. Conduct inspections of state drinking water systems in a timely manner as required by the SDW IGA.
12. Follow-up on drinking water alerts and non-compliance issues as required by the SDW IGA.
13. Complete the Environmental Health Surety Plan.
14. Work towards combined epi work (CD, EH, Prep.) in responding to public health events.

Activities:

1. Conduct health inspections of all licensed facilities as required by SFP IGA.
2. Conduct inspections of unlicensed facilities as requested by those facilities (certified day cares, group homes, jails, sororities, fraternities).
3. Maintain on-line and walk-in testing and licensing for food handlers and managers in Lane County as required by SFP IGA.
4. Perform investigations for citizen complaints on potential health hazards in licensed facilities as required by SFP IGA.
5. Perform epidemiological investigations related to public facilities as requested.
6. Provide environmental health education to the public as requested.
7. Document, follow-up and communicate with local animal control services and Oregon Health Authority on animal bites as required by DHS. Coordinate with local jurisdictions regarding animal bites.
8. The EH supervisor will continue work with interns on FDA Standards.
9. The EH supervisor will continue work with the Information Services Department, Conference of Local Environmental Health Supervisors (CLEHS) and Oregon Health Services Environmental Health program regarding option of electronic inspection program.

10. The EH Supervisor will work with CD Nurse Supervisor to develop noro-virus prevention training for nursing homes.
11. The EH Supervisor will ensure that staff is properly trained and oriented to the responsibilities of the recently added State Drinking Water Program.
12. The EH Supervisor will work with the State Drinking Water Program staff to ensure that all elements of the program are met.
13. Staff are assigned and exercise plans in completing the Environmental Health Surety Plan (according to the Preparedness Training/Exercise Plan).
14. Joint case investigation with CD and EH staff and after action review as indicated/appropriate.

Evaluation:

1. There will be a record and numerical score for each food service inspection. The record will be maintained in the EH database. In addition, a file will be maintained for each facility as required by the SFP IGA.

Family Planning

Current condition or problem:

1. We have slightly decreased the number of Family Planning visits at which Plan B for future use was dispensed from 19.2% in FY 2009 to 18 1% in 2010. As noted in program element 41 3.a.ii of the DHS IGA we are to provide a broad range of contraceptive methods.
2. Male FP Services are now available at Community Health Centers (CHC) of Lane County at Springfield High School. Male students have not started using the service. As noted in program element 41 of the DHS IGA, we are to provide clinical, informational, educational, social and referral services to anyone of reproductive age requesting family planning and reproductive health care.

Goals:

1. To promote awareness and access to Emergency Contraception among Oregonians at risk for unintended pregnancy.
2. To direct services to address disparities among Oregon's high priority and underserved populations, including Hispanics, limited English proficient (LEP), Native Americans, African Americans, Asian Americans, rural communities, men, uninsured and persons with disabilities.

Activities:

1. Review Plan B at Provider FP update and review use of CVR.
2. Information session specifically with the pediatric staff.

3. Educate or refresh ED information to all CMAs and nurses to ask about Plan B at every FP visit.
4 Put up Plan B signs and posters in the exam rooms of the new clinic.
5. Review male family planning services at FP Provider update scheduled 1/27/11. Discuss opening these services in all clinics immediately as opposed to the high school pilot program.
6. Attend the Male Services Capacity Building Institute Title X training to develop and implement a successful male family planning program.

Evaluation:

1. Meeting scheduled for 1/27/11 completed.
2. Information session to be scheduled.
3. Visual inspection of rooms to ensure posters are displayed.
4. Ultimately our CVR data will indicate a continual increase in the number of Family Planning clients receiving Plan B for future use.
5. Get staff feedback during and after the meeting.
6. Utilize recommended messaging and look for an increase in appointments via Ahler's data.
7. Male visits can be evaluated using CVR data.

Health Information and Referral Services

Current condition or problem:

Lane County Public Health provides health information and referral services five days a week in all Eugene program offices

Goal:

To continue providing up to date health information and referral services to citizens who call or come into the public health office.

Activities:

1. Maintain support staff to answer phone calls and greet people in the office and to provide current health information and referral services as requested.
2. Coordinate information between particular teams within public health and the support staff in order that information is current.
3. Maintain current information regarding clinic hours and services provided through written and oral format as well as website.
4. Maintain current information regarding eligibility and access to services provided by public health.
5. Continue communication with community agencies and medical providers in rural areas of the county for information and referral services in those areas.
6. Maintain current website information.

Evaluation:

1. Structure of support staff schedule will be reviewed to ensure availability of staff to provide health information and referral services.
2. Minutes of public health program team meetings will be kept and shared with support staff to keep up to date information regarding our services.
3. Clinic schedules will be reviewed periodically for accuracy – schedules will be provided in English and Spanish.
4. Staff will be encouraged to check the Lane County Public Health website often to make sure the information is accurate. One person maintains website changes and suggestions in order to keep fidelity in the website information.

Healthy Communities Program Objectives

Best Practice Objective #1: Infrastructure for Self-Management Programs, Early Detection and Tobacco Cessation Resources.

SMART Objectives:

1. By June 2012, support loving Living Well/Tomando Coordinator's (Bev Cridland housed at Peace Health's Gerontology Institute) efforts to maintain our local living Well/Tomando program delivery infrastructure and associated referral system by fostering Lane County's Federally Qualified Health Center's interest in participating in the Oregon Primary Care Association's Patient Self-management Collaborative (abbreviated as OPCA PSMC below) [Infrastructure for and Referral to Self-Management programs].
2. By June 2012, all Lane County WIC service delivery staff will continue to implement an evidence-based 3As tobacco cessation intervention with clients who use tobacco, offer tobacco using clients information on the Quitline, and refer interested and appropriate clients (those interested in quitting in the next 30 days) to the Quitline via the fax referral form [Tobacco Cessation Resources].
3. By June 2012, Lane County will develop and implement an organizational policy to regularly promote the evidence-based Chronic Disease Self-Management Programs (Living Well, tomando and others identified) available in the community to county employees, dependents and retirees living with chronic conditions. [Referral to Self-Management Programs]
4. By June 2012, Lane County will develop and implement an organizational policy to regularly encourage employees,

beneficiaries, and retirees to obtain recommended screenings for colorectal, breast and cervical cancer. [Early Detection]

5. By June 2012, Lane County will develop and implement an organizational policy to encourage covered employees, beneficiaries and covered retirees to get recommended blood pressure and cholesterol screenings and follow up with recommended treatment to keep high blood pressure and cholesterol under control. [Early Detection]
6. By June 2012, Lane County will develop and implement an organizational policy to regularly promote the tobacco cessation benefits included in the county's health insurance plan to covered employees, beneficiaries and covered retirees. The Oregon Tobacco Quitline will be simultaneously promoted to county employees and family members ineligible for county health insurance. [Tobacco Cessation Resources]
7. By June 2012, EC Coordinator will continue to participate in quarterly Well Group (local worksite wellness coalition) meetings to encourage other large local employers to consider implementing SMART Objectives 2-6 and other evidence-based worksite wellness policies and interventions at their own organizations.

Best Practice Objective #2: Healthy Worksites

SMART Objectives:

1. By June 2012, goal is that remaining H&HS properties will transition to tobacco-free status and a formal H&HS tovacco-free campus policy will be adopted, incorporated into the Departmental policy manual, and distributed by e-mail to all H&HS staff.
2. By June 2012, establish and implement a regular schedule to conduct tobacco-use environmental assessments at all H&HS properties to ensure compliance with new policy and address problem areas and build champions to continue policy assessment and communication efforts into perpetuity.
3. By June 2012, Lane County Department Directors, Central Administration Office, Human Resources, and Board of County Commissioners/Board of Health will have participated in educational sessions to increase understanding of the importance of adopting a county-wide tobacco-free properties policy.
4. By June 2012, the Lane County Public Health Division (~50 FTE) will adopt and implement a combined healthy food and physical activity at meetings policy for all public health-sponsored meetings and events.
5. By June 2012, conduct Department-wide educational efforts to increase H&HS employees' support for healthier worksite food and physical activity environments.

Best Practice Objective #3: Healthy Retail Environments

SMART Objective

1. By June 2012, workgroup including Lane Coalition for Healthy Active Youth (LCHAY), Public Health, Oregon Research Institute, the Willamette Food and Farm Coalition, Shelter Care, the Housing and Community Services Agency of Lane County, and Dari Mart will develop a policy proposal to increase availability of healthy, affordable food at convenience stores.

ACHIEVE Grant: Public Health received a three-year CDC-funded technical assistance grant from the National Association of Chronic Disease Directors in February 2011. This three year initiative includes the creation of a Community Health Action and Response Team (CHART) comprised of community leaders from a variety of sectors. Under this initiative public health will lead collaborative assessments of local worksites, schools, community organizations, health care settings, and the community at large with CHART members. Once the assessment is complete, CHART members will work together to draft and implement a multi-year Community Action Plan focused on chronic disease prevention.

Parent and Child Health

- **Prenatal Access, Oregon Mothers Care:**

Current condition or problem:

1. The percentage of Lane County pregnant women receiving first trimester care in 2010 was 76.8%, a slight improvement. the Oregon percentage in 2010 was 73.4%. The Oregon Benchmark goal is 95%.
2. Lane County's prenatal access program, Oregon Mothers Care (OMC) assists pregnant teen and adult women access Oregon Health Plan (OHP) coverage and early prenatal care by helping remove barriers, per program element in the Intergovernmental Agreement with DHS.
3. The local OMC provides education regarding importance of dental care during pregnancy and encourages pregnant women to access dental care.

Goals:

1. Increase the number of pregnant women who access prenatal care during the first trimester as noted in the program element for OMC. (Noted in Program Element 42 in Oregon Health Authority IGA.)
2. Increase the number of OHP eligible pregnant and postpartum women who access dental care services.

Activities:

1. Provide pregnancy testing and counseling, assist in gaining OHP coverage and prenatal care, and referral to MCH and WIC (Special Supplemental Nutrition Program for Women, Infants, and Children).

2. Provide community outreach regarding the need for early prenatal care and the local OMC program as noted in the OMC Program Element.
3. Continue collecting and submitting client data quarterly to state as noted in OMC Program Elements in the IGA with DHS.
4. At each appointment with pregnant woman, staff will address healthy behaviors and importance of taking prenatal vitamins – vitamins will be provided to pregnant women at no charge.
5. Continue collaboration with Community Health Centers of Lane County in assisting pregnant women to access OHP services.

Evaluation:

1. OMC staff will use electronic medical record system for tracking client information. OMC staff will continue to send data to the state in agreed upon manner.
2. OMC staff will record program outputs and outcomes as part of the countywide performance measure process.
3. Excel spreadsheet will be maintained to track distribution of brochures and other outreach materials. Noted in OMC Program Elements in IGA with DHS.

- **Maternal Child Health, Maternity Case Management (MCM), Babies First!**

Current condition or problem:

1. Lane County's fetal-infant mortality rate is higher than the rate for Oregon and the U.S. The most current data indicates that Lane County's rate has improved (decreased) and is now closer to the Oregon rate (Lane – 8.25; Oregon – 8.0). Initial data continues to indicate that the highest rate of excess death is in the post-neonatal period (29 days to 1 year of age); and, the second highest excess mortality is related to maternal health and prematurity. Among post neonatal deaths during the two years of fetal infant mortality review, unsafe sleep practices were noted 40% of the time.
2. Collaborative partnerships with health providers and other service agencies have resulted in continued referrals for MCH services.
3. Public Health Nurses (PHNs) provide comprehensive Maternity Case Management (MCM) home visiting services for many women who are at risk of poor pregnancy and birth outcomes.
4. PHNs provide Babies First services for infants and young children at significant risk of poor health or developmental outcomes.
5. PHNs provide CaCoon services to help families become as independent as possible in caring for their child with special health or developmental needs and help in accessing appropriate services.
6. PHNs provide support and assistance for families who have experienced a child's death by SIDS (Sudden Infant Death

Syndrome). The Fetal Infant Mortality Review group case team reviews all fetal/infant deaths.

Goals:

1. Reduce Lane County's unacceptably high rate of fetal-infant mortality
2. Increase the number/rate of births that are full-term (≥37 weeks) and appropriate weight (≥ 6 lbs.)
3. Decrease the number of pregnant women who use alcohol, tobacco, or illicit drugs during pregnancy.
4. Optimize birth and childhood outcomes for at-risk families through education, referral and support.
5. Prevent and mitigate early developmental delays, ensure early intervention of delays that are identified, and optimize each child's potential capacity.
6. Increase family independence in caring for children with special needs.
7. Maintain up to date data entry into ORCHIDS.

Activities:

1. Facilitate the community initiative for the reduction of fetal-infant mortality.
2. Work to fund and continue the FIMR (Fetal Infant Mortality Review) process in Lane County.
3. Provide comprehensive, quality MCM nurse home visiting by well trained and capable PHNs for at risk pregnant teen and adult women. (As noted in Program Element 42 of Oregon Health Authority IGA.)
4. Provide quality Babies First and CaCoon nurse home visiting services by well trained and capable PHNs. (As noted in Program Element 42 of Oregon Health Authority IGA.)
5. Provide nurse home visiting support for families who have experienced a SIDS death. (As noted in Program Element 42 of Oregon Health Authority IGA.)
6. Work closely with WIC to ensure a system of public health services for families in need.
7. Participate in local Commission on Children and Families SB 555 early childhood planning efforts.
8. Ensure staff assigned to do data entry into ORCHIDS for current client data to state. (As noted in Program Element 42 of Oregon Health Authority IGA.)

Evaluation:

1. MCM, Babies First!, and CaCoon data will be recorded in ORCHIDS MDE, the statewide MCH system.
2. MCH referral logs will be maintained to track referrals for MCH services and identify referral sources.

3. PHNs will maintain a case log that indicates the outcome of client contact.
4. PHNs, with the assistance of ancillary staff, will record program outputs and outcomes as part of the countywide performance measure process.

Public Health Emergency Preparedness

Goals, objectives and activities are provided on pages 14 and 15 of this document as well as within the Communicable Disease and Environmental Health Action Plans.

Tobacco Prevention Program Objectives

- By June 2012, Lane County TPEP Coordinator will have partnered with Lane County HC Coordinator and other partners on a minimum ot two collaborative efforts (Lane County Worksite Wellness Program Implementation Committee and new ACHIEVE grant) aimed at chronic disease prevention, early detection and self-management that is broader than, but also includes tobacco prevention. By June 2011, TPEP/HC staff will have met with a minimum of 5 local policy makers (outside of the Board of County Commissioners) to share local chronic disease prevalence data and information on local success stories for the purpose of increasing general support for the program and assessing political feasibility of future policy work.
- By June 2012, goal is that the remaining Lane County H&HS properties will transition to tobacco-free status and a formal H&HS tobacco-free campus policy will be adopted, incorporated into the Departmental policy manual, and distributed by e-mail to all H&HS staff.
- By June 2012, establish and implement a regular schedule to conduct tobacco-use environmental assessments at all H&HS properties to ensure compliance with new policy and address problem areas and build champions to continue policy assessment and communication efforts into perpetuity.
- By June 2012, Lane County Department Directors, Central Administration Office, Human Resources, and Board of County Commissioners/Board of Health will have participated in educational sessions to increase understanding of the importance of adopting a county-wide tobacco-free properties policy.
- By June 2012, Lane County Public Health will have responded to all complaints of violation of the Smokefree Workplace Law according to the protocol specified in the IGA.

- By June 2012, the City of Eugene will have made changes to City Code 6.225-6.240 "Tobacco Products and Smoking" that will eliminate or redefine the Tobacco Retail Shop exemption in such a way that it no longer allows for the establishment of smoking lounges.
- By June 2010, one of the two largest affordable housing providers in Lane County (excluding HACSA, our public housing authority) will have adopted a smokefree housing policy for all agency owned/managed properties. Staff will be working with Metro Affordable Housing Incorporated (419 units) and St. Vincent de Paul (over 1,000 units).
- By June 2012, Lane Community College will have adopted a revision to its current "Tobacco Free Core Campus" policy that will eliminate designated smoking areas in parking lots, therefore making the campus truly 100% Tobacco Free.
- By Fall 2012, the University of Oregon will have implemented its Tobacco Free Campus Policy.
- By June 2012, the City of Eugene will have updated sections of Code 3.500-3.515 pertaining to Tobacco Products Retail Licenses in such a way than an increased licensing fee will cover the costs associated with bi-annual inspections of all tobacco retail outlets and any other subsequent enforcement requirements.

Breast and Cervical Cancer Screening Program – Community Health Centers of Lane County, a division of the Lane County Department of Health and Human Services has a Medical Services Agreement with Oregon Health Authority/Public Health Division to provide this program in Lane County.

IV. Additional Requirements

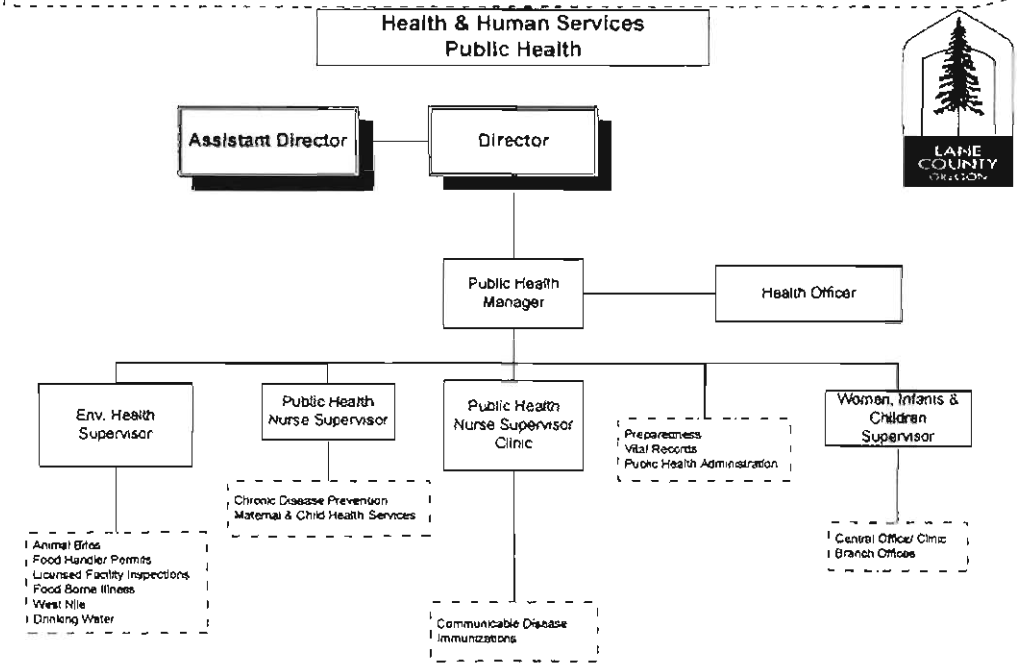
1. The organizational chart for Lane County Public Health Services is on the page following SB 555.
2. The Lane County Board of County Commissioners serves as the Board of Health. Minimally, they convene every six months to receive the Lane County Department of Health and Human Services six month Board of Health Report. This report includes all divisions of the department, ranging from Public Health to Behavioral Health to Family Mediation. The report is a public document and available to anyone who requests it. It is also posted on the department's website. In addition, when requested by our Department Director/Health Administrator, the Board of Health convenes on public health policy issues. With the assistance from our County Counsel, the Board of Health has developed better understanding of their authority to pursue and set policy at the local level to ensure improved community health. The Board of Health meetings are public meetings, with notice to the community. The Department Director of Health and Human Services (Health Administrator) reports to the County Administrator and the Board of County Commissioners.

3. Lane County Public Health has an Advisory Committee which meets the second Tuesday evening of each month (5:30-7:00 pm). There are twelve members on the committee which includes seven at-large members and five Oregon licensed members (physician, dentist, nurse, etc.) Committee members have assisted Lane County Public Health in the work of the strategic plan, the tracking grid for the plan, the Healthy Babies Healthy Communities Coalition work, chronic disease prevention, herbicide spraying issues, to name a few. The committee members are strong supporters of public health and the work the staff are doing. The committee is provided program updates from staff and has identified those areas they want to focus on each year which is reported to the Board of County Commissioners, which they are advisory to on public health matters. For 2011, the committee has identified the following major themes/work proposed to the commissioners: chronic disease prevention (tobacco-free policies, obesity prevention); develop and implement strategies to decrease the use of tobacco products in high schools; air quality issues; healthy food choices, dental health and access to dental health services; receive information on primary care center for Medicare and low-income patients at the CHC; develop a quarterly and annual process for quality review of impact on changes to Lane Code 18 (Ambulance Service Areas); collaborate with Oregon Health Authority/Public Health to improve provider education regarding "expedited partner treatment" for sexually transmitted diseases; and seek information on how to meet the standard of care by increasing number of pneumonia immunizations given to seniors. The committee also presented to the Board of Health in recognition of Public Health Week on April 5, 2011.

4. Senate Bill 555: During its last Comprehensive Planning process which ended in early 2008, Lane County prioritized three community focus issues: 1) Increasing effective community supports for Youth in Transition (YIT) with moderate to severe mental health issues; 2) Increasing quality infant toddler child care slots; and 3) Developing strategies to increase our quality and capacity in home visiting programs to reduce child maltreatment. Public Health has played a variety of roles during the planning and implementation phases of the collaborative efforts the community has developed addressing these focus issues. This has included strategic and resource development, program planning, coordination, networking and community education. Two out of the three focus issues are priorities which grew out of the Early Childhood Planning Team. The focus on home visiting came about as a collaborative effort including the Commission on Children and Families, Public Health, Department of Human Services, United Way, schools and social service agencies, because this strategy has had a positive impact on reducing a community's fetal/infant mortality rate as well as reducing child maltreatment. Public Health will continue

to be involved in both the home visiting and youth with mental health needs focus issues.

Comment [BTC1]:



Public Health Department Structure
Last Update 03/2011

V. Unmet Needs

As Lane County Public Health Services begins a new fiscal year, our projected budget provides funding at a level of service the same as FY 10/11. In the action plan of this document, we have identified activities which are priorities to meet some of our county's needs. We continue to work on providing mandated services and maintain our local public health authority.

In previous years of reductions, we have had to close the three branch offices for public health (Oakridge, Florence, Cottage Grove). Serving the rural residents of our county with public health services (family planning, immunizations, maternal child health, communicable disease) in their communities continues to be an unmet need. Services continue to be available in the central (Eugene) office, but transportation to Eugene for many of these citizens is problematic. We have been able to continue nurse home visiting throughout the county, although we are not able to take on all the referrals given each month. Limited WIC services in Cottage Grove, Oakridge and Florence continues, however, there are long waits for clients to access these services due to limited number of times per month staff are in the rural areas. Our Environmental Health staff continue to provide inspections of all licensed facilities throughout the county.

The recent publication from the University of Wisconsin on County Health Rankings provided a snapshot view of some of the factors that contribute to the health of Lane County. Our overall ranking of 18 out of 33 counties was not a surprise, since we know the air quality issues we face at the end of the Willamette Valley and our rates of diabetes, obesity, chlamydia and low birth weight babies are significant. We have struggled with supporting a Chronic Disease Prevention Program in order to maintain sustainability, since much policy work needs to be done at the local level if we are to reduce morbidity and mortality related to tobacco use and lack of physical activity and nutrition. Our staff has done amazing work with the state tobacco prevention funding and Healthy Communities funding, however, it will become necessary for us to continue searching for other funding as well in order to address these significant public health issues at a policy level. Strong local community relationships have been built as well as across the state in chronic disease prevention and the need is great to continue the work.

Within MCH and local agencies, we have a strong working relationship and referral process. These agencies continue to support the provision of nurse home visits for high risk families and know that the visits are critical to reducing child abuse and neglect as well as increasing the health of our children. We are able to provide a number of home visits, although the need for more nurses to provide prevention services is greater than the funding allows. There are several referrals each month to our MCH team that cannot be assigned, not because they aren't a high enough risk, but due to insufficient nurse staff to accommodate the increasing need in our community. We continually look for resources to fund a Nurse Family Partnership for our Maternal Child Health Program. We are committed to continuing this effort, applying for federal grants and for

the past couple years the NFP has been part of the Lane County United Front effort in Washington, D.C.

The largest initiative we have begun has been the concern over the Fetal Infant Mortality rate in Lane County. This has been addressed in other sections of this plan, and it continues to be a priority for our work. A Fetal Infant Mortality Review (FIMR) process continues and has been instrumental in providing the necessary information in order for the coalition to make decisions regarding actions to take that will reduce the mortality rate. We have an active coalition (Healthy Babies, Healthy Communities) working to find the areas to strengthen in our community in order to reduce the mortality rate. As much as we want to continue this effort, we continually look for funding to support the effort as well as funding to establish a Nurse Family Partnership (NFP) model for nurse home visiting as noted above. These two efforts would make a substantial difference to the health and well being of the families and babies we serve.

VI. Budget

The contact person for the approved annual budget for Lane County Public Health is Lynise Kjolberg, Administrative Services Supervisor, Dept. of Health and Human Services. Her phone number is (541) 682-3968; e-mail is lynise.kjolberg@co.lane.or.us. The budget is presented by individual programs and will be submitted to the state per each of the program required timelines.

VII. Minimum Standards

To the best of your knowledge are you in compliance with these program indicators from the Minimum Standards for Local Health Departments:

Organization

1. Yes _X_ No ___ A Local Health Authority exists which has accepted the legal responsibilities for public health as defined by Oregon Law.

2. Yes _X_ No ___ The Local Health Authority meets at least annually to address public health concerns.

3. Yes _X_ No ___ A current organizational chart exists that defines the authority, structure and function of the local health department; and is reviewed at least annually.

4. Yes ___ No _X_ Current local health department policies and procedures exist which are reviewed at least annually. Note: Policies and procedures exist but are not reviewed on an annual basis. We have department and program policies and procedures that are reviewed and updated as needed.

5. Yes ___ No _X_ Ongoing community assessment is performed to analyze and evaluate community data. Note: A formal analysis is not done. We do community analysis as needed regarding specific program issues.

6. Yes _X_ No ___ Written plans are developed with problem statements, objectives, activities, projected services, and evaluation criteria. Note: As a county and department, we have been writing performance measures and data collection forms. This is an ongoing process.

7. Yes _X_ No ___ Local health officials develop and manage an annual operating budget.

8. Yes _X_ No ___ Generally accepted public accounting practices are used for managing funds.

9. Yes _X_ No ___ All revenues generated from public health services are allocated to public health programs.

10. Yes _X_ No ___ Written personnel policies and procedures are in compliance with federal and state laws and regulations.

11. Yes _X_ No ___ Personnel policies and procedures are available for all employees.

12. Yes _X_ No ___ All positions have written job descriptions, including minimum qualifications.

13. Yes _X_ No ___ Written performance evaluations are done annually. Note: we strive to do this.

14 Yes _X_ No ___ Evidence of staff development activities exists. Note: staff note on their electronic time cards all trainings they attend.

15. Yes _X_ No ___ Personnel records for all terminated employees are retained consistently with State Archives rules.

16. Yes _X_ No ___ Records include minimum information required by each program.

17. Yes ___ No _X_ A records manual of all forms used is reviewed annually. Note: a review is not completed on an annual basis. Forms are reviewed and updated as needed.

18. Yes _X_ No ___ There is a written policy for maintaining confidentiality of all client records which includes guidelines for release of client information.

19. Yes _X_ No ___ Filing and retrieval of health records follow written procedures.

20. Yes __X No ___ Retention and destruction of records follow written procedures and are consistent with State Archives rules.

21. Yes _X_ No ___ Local health department telephone numbers and facilities' addresses are publicized.

22. Yes _X_ No ___ Health information and referral services are available during regular business hours.

23. Yes _X_ No ___ Written resource information about local health and human services is available, which includes eligibility, enrollment procedures, scope and hours of service. Information is updated as needed.

24. Yes _X_ No ___ 100% of birth and death certificates submitted by local health departments are reviewed by the local Registrar for accuracy and completeness per Vital Records office procedures.

25. Yes _X_ No ___ To preserve the confidentiality and security of non-public abstracts, all vital records and all accompanying documents are maintained. Note: records are maintained in a confidential manner.

26. Yes _X_ No ___ Certified copies of registered birth and death certificates are issued within one working day of request.

27. Yes ___ No _X_ Vital statistics data, as reported by the Center for Health Statistics, are reviewed annually by local health departments to review accuracy and support ongoing community assessment activities. Note: Not reviewed on an annual basis.

28 Yes _X_ No ___ A system to obtain reports of deaths of public health significance is in place.

29. Yes _X_ No ___ Deaths of public health significance are reported to the local health department by the medical examiner and are investigated by the health department.

30. Yes ___ No _X_ Health department administration and county medical examiner review collaborative efforts at least annually. Note: Efforts are not reviewed on an annual basis, but as the need arises. Health Officer works with District Attorney's office as needed to collaborate with the work of the Deputy Medical Examiner.

31. Yes _X_ No ___ Staff is knowledgeable of and has participated in the development of the county's emergency plan.

32. Yes _X_ No ___ Written policies and procedures exist to guide staff in responding to an emergency.

33. Yes _X_ No ___ Staff participate periodically in emergency preparedness exercises and upgrade response plans accordingly.

34. Yes _X_ No ___ Written policies and procedures exist to guide staff and volunteers in maintaining appropriate confidentiality standards.

35. Yes _X_ No ___ Confidentiality training is included in new employee orientation. Staff includes: employees, both permanent and temporary, volunteers, translators, and any other party in contact with clients, services or information. Staff sign confidentiality statements when hired and at least annually thereafter.

36. Yes _X_ No ___ A Client Grievance Procedure is in place with resultant staff training and input to assure that there is a mechanism to address client and staff concerns.

Control of Communicable Diseases

37. Yes _X_ No ___ There is a mechanism for reporting communicable disease cases to the health department.

38. Yes _X_ No ___ Investigations of reportable conditions and communicable disease cases are conducted, control measures are carried out, investigation report forms are completed and submitted in the manner and time frame specified for the particular disease in the Oregon Communicable Disease Guidelines.

39. Yes __ No _X__ Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or communicable disease case received. (Note: Physician is contacted during investigation and at other times as requested by physician or as indicated by the investigation.)

40. Yes _X_ No ___ Access to prevention, diagnosis, and treatment services for reportable communicable diseases is assured when relevant to protecting the health of the public.

41. Yes _X_ No ___ There is an ongoing/demonstrated effort by the local health department to maintain and/or increase timely reporting of reportable communicable diseases and conditions.

42. Yes _X_ No ___ There is a mechanism for reporting and following up on zoonotic diseases to the local health department.

43. Yes _X_ No ___ A system exists for the surveillance and analysis of the incidence and prevalence of communicable diseases.

44. Yes _X__ No __ Annual reviews and analysis are conducted of five year averages of incidence rates reported in the Communicable Disease Statistical Summary, and evaluation of data are used for future program planning.

45. Yes _X_ No ___ Immunizations for human target populations are available within the local health department jurisdiction.

46. Yes _X_ No ___ Rabies immunizations for animal target populations are available within the local health department jurisdiction. (Note: Available in Lane County, not at Lane County Public Health.)

Environmental Health

47. Yes _X_ No ___ Food service facilities are licensed and inspected as required by Chapter 333 Division 12.

48. Yes _X_ No ___ Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.

49. Yes _X_ No ___ Training in first aid for choking is available for food service workers. (Note: In Food Handlers Manual-English and Spanish.)

50. Yes _X_ No ___ Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided. (Note: Through Red Cross.)

51. Yes X_ No ___ Each drinking water system conducts water quality monitoring and maintains testing frequencies based on the size and classification of system.

52. Yes _X___ No ___ Each drinking water system is monitored for compliance with applicable standards based on system size, type, and epidemiological risk.

53. Yes _X__ No ___ Compliance assistance is provided to public water systems that violate requirements.

54. Yes _X__ No ___ All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken.

55. Yes X_ No ___ A written plan exists for responding to emergencies involving public water systems.

56. Yes __X_ No ___ Information for developing a safe water supply is available to people using on-site individual wells and springs.

57. Yes _X_ No ___ A program exists to monitor, issue permits, and inspect on-site sewage disposal systems. Note: Through the Public Works Department, Land Management Division for Lane County.

58. Yes _X_ No ___ Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.

59. Yes _X_ No ___ School and public facilities food service operations are inspected for health and safety risks. (Note: At request of school districts.)

60. Yes _X_ No ___ Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12.

61. Yes _X_ No ___ A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste. (Note: Through Department of Public Works, Waste Management Division of Lane County.)

62. Yes _X_ No ___ Indoor clean air complaints in licensed facilities are investigated.

63. Yes _X_ No ___ Environmental contamination potentially impacting public health or the environment is investigated.

64. Yes _X_ No ___ The health and safety of the public is being protected through hazardous incidence investigation and response. (Note: Through Lane County Sheriff's Office, HazMat and Public Health.)

65. Yes _X_ No ___ Emergency environmental health and sanitation are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control. (Note: In coordination with Department of Public Works,

Department of Environmental Quality and State Water Program, Public Health.)

66. Yes _X_ No ___ All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448. (Added per G.S. request, not in program indicators)

Health Education and Health Promotion

67. Yes _X_ No ___ Culturally and linguistically appropriate health education components with appropriate materials and methods will be integrated within programs.

68. Yes _X_ No ___ The health department provides and/or refers to community resources for health education/health promotion.

69. Yes _X_ No ___ The health department provides leadership in developing community partnerships to provide health education and health promotion resources for the community.

70. Yes _X_ No ___ Local health department supports healthy behaviors among employees.

71. Yes _X_ No ___ Local health department supports continued education and training of staff to provide effective health education.

72. Yes _X_ No ___ All health department facilities are smoke free.

Nutrition

73. Yes _X__ No __ Local health department reviews population data to promote appropriate nutritional services. (Note: Within TROCD grant our PHE looks at BMI community data and BRFS)

74. The following health department programs include an assessment of nutritional status:

a. Yes _X_ No ___ WIC
b. Yes _X_ No ___ Family Planning
c. Yes _X_ No ___ Parent and Child Health
d. Yes ___ No _X_ Older Adult Health
e. Yes ___ No _X_ Corrections Health

75. Yes _X_ No ___ Clients identified at nutritional risk are provided with or referred for appropriate interventions.

76. Yes _X_ No ___ Culturally and linguistically appropriate nutritional education and promotion materials and methods are integrated within programs.

77. Yes _X_ No ___ Local health department supports continuing education and training of staff to provide effective nutritional education.

Older Adult Health

78. Yes _X_ No ___ Health department provides or refers to services that promote detecting chronic diseases and preventing their complications.

79. Yes _X_ No ___ A mechanism exists for intervening where there is reported elder abuse or neglect. Note: Contact Lane County Senior Services.

80. Yes _X_ No ___ Health department maintains a current list of resources and refers for medical care, mental health, transportation, nutritional services, financial services, rehabilitation services, social services, and substance abuse services.

81. Yes _X__ No __ Prevention-oriented services exist for self health care, stress management, nutrition, exercise, medication use, maintaining activities of daily living, injury prevention and safety education. (Note: We do try to provide information and referral if people call regarding these services. We do not provide services directly.

Parent and Child Health

82. Yes _X_ No ___ Perinatal care is provided directly or by referral.

83. Yes _X_ No ___ Immunizations are provided for infants, children, adolescents and adults either directly or by referral.

84. Yes _X_ No ___ Comprehensive family planning services are provided directly or by referral. (As of July 1, 2006, Family Planning is now provided through the Federally Qualified Health Center within the Department of Health and Human Services.)

85. Yes _X_ No ___ Services for the early detection and follow up of abnormal growth, development and other health problems of infants and children are provided directly or by referral.

86. Yes _X_ No ___ Child abuse prevention and treatment services are provided directly or by referral.

87. Yes _X_ No ___ There is a system or mechanism in place to assure participation in multi-disciplinary teams addressing abuse and domestic violence. (Note: Supervisor member of MDT.)

88. Yes _X_ No ___ There is a system in place for identifying and following up on high risk infants.

89. Yes _X_ No ___ There is a system in place to follow up on all reported SIDS deaths.

90. Yes _X_ No ___ Preventive oral health services are provided directly or by referral. (Note: Provided through referral only. Public Health Nurses on home visits discuss the importance of good oral health, prevention, nutrition.)

91. Yes _X__ No __ Use of fluoride is promoted, either through water fluoridation or use of fluoride mouth rinse or tablets. (Note: MCH nurses talk with families about importance of dental care and fluoride rinse and varnishes.)

92. Yes _X_ No ___ Injury prevention services are provided within the community.

Primary Health Care

93. Yes _X_ No ___ The local health department identifies barriers to primary health care services.

94. Yes _X_ No ___ The local health department participates and provides leadership in community efforts to secure or establish and maintain adequate primary health care.

95. Yes _X_ No ___ The local health department advocates for individuals who are prevented from receiving timely and adequate primary health care.

96. Yes _X_ No ___ Primary health care services are provided directly or by referral. (Note: By referral only) The Community Health Centers of Lane County in the H&HS Department has been a partner with us and a valuable referral for the uninsured, underinsured and those with OHP and insurance coverage.

97. Yes _X_ No ___ The local health department promotes primary health care that is culturally and linguistically appropriate for community members.

98. Yes _X_ No ___ The local health department advocates for data collection and analysis for development of population based prevention strategies. Note: Are developing performance measures and data collection processes.

Cultural Competency

99. Yes _X_ No ___ The local health department develops and maintains a current demographic and cultural profile of the community to identify needs and interventions. (Note: This is limited information, utilizing Lane Council of Governments information and through the U.S. Census and Portland State University information.)

100. Yes _X_ No ___ The local health department develops, implements and promotes a written plan that outlines clear goals, policies and operational plans for provision of culturally and linguistically appropriate services. (Note: Within the county and department documents.)

101. Yes _X_ No ___ The local health department assures that advisory groups reflect the population to be served. (Note: this is our goal, however the recruitment process often doesn't provide a cross section of individuals.)

102. Yes _X_ No ___ The local health department assures that program activities reflect operation plans for provision of culturally and linguistically appropriate services.

Health Department Personnel Qualifications

Local health department Health Administrator minimum qualifications:

The Administrator must have a Bachelor degree plus graduate courses (or equivalents) that align with those recommended by the Council on Education for Public Health. These are: Biostatistics, Epidemiology, Environmental Health Sciences, Health Services Administration, and Social and Behavioral Sciences relevant to public health problems. The Administrator must demonstrate at least 3 years of increasing responsibility and experience in public health or a related field.

Answer the following questions:

Administrator name: Rob Rockstroh

Does the Administrator have a Bachelor degree: Yes_X_ No___
Does the Administrator have at least 3 years experience in public health or a related field? Yes _X_ No___
Has the Administrator taken a graduate level course in biostatistics? Yes_X_ No___
Has the Administrator taken a graduate level course in epidemiology? Yes_X No___
Has the Administrator taken a graduate level course in environmental health? Yes_X_ No___
Has the Administrator taken a graduate level course in health services administration? Yes_X_ No__
Has the Administrator taken a graduate level course in social and behavioral sciences relevant to public health problems? Yes_X_ No__

a. Yes_X_ No ___ The local health department Health Administrator meets minimum qualifications.

If the answer is "No", submit an attachment that describes your plan to meet the minimum qualifications.

b. Yes X No The local health department Supervising Public Health Nurse meets minimum qualifications:

Licensure as a registered nurse in the State of Oregon, progressively responsible experience in a public health agency;

AND

Baccalaureate degree in nursing, with preference for a Master's degree in nursing, public health or public administration or related field, with progressively responsible experience in a public health agency.

c. Yes X No The local health department Environmental Health Supervisor meets minimum qualifications:

Registration as a sanitarian in the State of Oregon, pursuant to ORS 700.030, with progressively responsible experience in a public health agency

OR

a Master's degree in an environmental science, public health, public administration or related field with two years progressively responsible experience in a public health agency.

d. Yes X No The local health department Health Officer meets minimum qualifications:

Licensed in the State of Oregon as M.D or D.O. Two years of practice as licensed physician (two years after internship and/or residency). Training and/or experience in epidemiology and public health.

Agencies are **required** to include with the submitted Annual Plan:

The local public health authority is submitting the Annual Plan pursuant to ORS 431.385, and assures that the activities defined in ORS 431.375-431.385 and ORS 431.416 are performed.

Local Public Health Authority	Lane County	Date

Liane I. Richardson
Acting County Administrator

PLEASE NOTE THAT THE FOLLOWING WIC ATTACHMENTS (A & B) AND THE IMMUNIZATIONS APPENDICES ARE TRANSMITTED ELECTRONICALLY TO SPECIFID DHS DEPARTMENTS. THEY ARE REQUIRED COMPONENTS OF THE ANNUAL AUTHORITY PLAN, BUT ARE NOT CONTAINED WITHIN THE PLAN DOCUMENT ITSELF. THEY ARE INCLUDED HERE TO ENSURE THIS RECORD OF THE ANNUAL AUTHORITY PLAN SUBMISSION IS COMPLETE, AS PRESENTED TO THE BOARD OF COMMISSIONERS.

FY 2011 - 2012 WIC Nutrition Education Plan Form

County/Agency: Lane County WIC Program
Person Completing Form: Leslie Houghton, MS, RD
Date: 03/23/ 2011
Phone Number: 541-682-4658
Email Address: leslie.houghton@co.lane.or.us

Goal: Incorporate PCE skills and strategies into group nutrition education classes.

Return this form electronically (attached to email) to: sara.e.sloan@state.or.us
by May 1, 2011
Sara Sloan, 971-673-0043

and centered education skills and strategies into group settings.

Activity 1: Local agency staff will attend a regional Group Participant Centered training focusing on content design to be held in the fall of 2011.

Note: Specific training logistics and registration information will be sent out prior to the trainings.

Implementation Plan and Timeline including possible staff who will attend a regional training:

Fall of 2011 all certifying staff will attend PCE training on content design put on by State WIC.

Activity 2: Each agency will modify at least one nutrition education group lesson plan from each category of core classes and at least one local agency staff in-service to include PCE skills and strategies by March 31, 2012. Specific PCE skills and strategies were presented during the PCE Groups trainings held Fall 2010 and Spring 2011.

Implementation Plan and Timeline:

In July 2011 we will review currently taught classes at our certifiers meeting to help staff who have not taught these classes familiarize themselves with content and PCE teaching techniques.

In August 2011 the staff currently teaching Prenatal and Breastfeeding classes will meet to discuss class content and format in further detail to provide advanced tips on using PCE skills, to update classes and to provide consistent messages.

In November 2011 we will have an in-service to review and practice PCE skills and strategies used in teaching groups. The final content will be determined after State WIC supplies the in-service outline and supporting resource materials. The in-service will be in a "Gallery Walk" format. Each certifier will provide a problem scenario which will be posted on the wall. We will individually walk around and compose and write down PCE solutions and strategies for each scenario. The solutions and ideas generated will be discussed afterward as a group.

Activity 3: Each agency will develop and implement a plan to familiarize all staff with the content and design of 2nd Nutrition Education options in order to assist participants in selecting the nutrition education experience that would best meet their needs.

Implementation Plan and Timeline:

The following is a time-line and explanation of how we are planning to update our staff on the content and design of second nutrition education options:

In May or June 2011 we will review our updated "High Risk Protocol" at a certifiers meeting.

In June 2011 we will update our staff class brochure.
In July 2011 we will review our revised class brochure at a certifiers meeting.

In July 2011 there will be a review of currently taught classes at our certifiers meeting to help staff who have not taught these classes familiarize themselves with content and PCE teaching techniques.

In May, June or July 2011 there will be a review of on-line classes at a certifiers meeting.

In August 2011 we will have the Nutrition Education Program staff (NEP) review their classes at the certifiers meeting.

Goal 2: **Oregon WIC staff will improve breastfeeding support for women in the prenatal and post partum time period.**

Year 2 Objective: During planning period, each agency will incorporate participant centered skills and strategies into their group settings to enhance their breastfeeding education, promotion and support.

Activity 1: Each agency will modify at least one prenatal breastfeeding class to include PCE skills and strategies by March 31, 2012. Specific PCE skills and strategies were presented during the PCE Groups trainings held Fall 2010 and Spring 2011.

Implementation Plan and Timeline:

The prenatal class has already been modified to include PCE sills and strategies.

In August 2011 staff who are currently teaching the Prenatal (and Breastfeeding) classes will meet to discuss class content and format in further detail to provide advanced tips on using PCE skills, to update classes and to provide consistent messages.

We will document how PCE is used in the teaching of the Prenatal Nutrition class from information gathered at the meeting.

Activity 2: Each agency's Breastfeeding Coordinator will work with the agency's Training Supervisor to provide an in-service to staff incorporating participant centered skills to support breastfeeding counseling.

Note: In-service content could include concepts from Biological Nurturing, Breastfeeding Peer Counseling Program – Group Prenatal Series Guide and/or Breastfeeding Basics – Grow and Glow Curriculum. An in-service outline and supporting resource materials developed by state WIC staff will be sent by July 1, 2011.

Implementation Plan and Timeline:

In December 2011 an in-service will be prepared and given on PCE skills used in breastfeeding counseling. We will use the outline and resource materials sent by State WIC. We again plan to do a "Gallery Walk" as in the October training. Each certifier will provide a problem scenario which will be posted on the wall. We will individually walk around and compose and write down solutions and strategies for each scenario. The solutions and ideas generated will be discussed afterward as a group.

Goal 3: **Strengthen partnerships with organization that serve WIC populations and provide nutrition and/or breastfeeding education.**

Year 2 Objective: During planning period, each agency will continue to develop strategies to enhance partnerships with organizations in their community that serve WIC participants by offering opportunities to strengthen their nutrition and/or breastfeeding education.

Activity 1: Each agency will invite at last one partner that serves WIC participants and provides nutrition education to attend a regional Group Participant Centered Education training focusing on content design to be held fall of 2011.

Note: Specific training logistics and registration information will be sent out prior to the trainings.

Implementation Plan and Timeline:

In August 2011 we will invite the Public Health Nurses (PHNs) and OSU Extension NEP staff to PCE training planned for Fall 2011

Activity 2: Each agency will invite at least one community partner that provides breastfeeding education to WIC participants to attend a Breastfeeding Basics – Grow and Glow Training complete the Oregon WIC Breastfeeding Module and/or complete the new online Oregon WIC Breastfeeding Course.

Note: Specific Breastfeeding Basics - Grow and Glow training logistics and registration information will be sent out prior to the trainings. Information about accessing the online Breastfeeding Course will be sent out as soon as it is available.

Implementation Plan and Timeline:

In August or September 2011 we will invite PHNs, Healthy Start staff and possibly Charnelton and Riverstone Health Clinics staff to a Breastfeeding Basics-Grow and Glow training or to complete the new on-line breastfeeding module.

Goal 4: **Oregon WIC staff will increase their understanding of the factors influencing health outcomes in order to provide quality nutrition education.**

Year 2 Objective: During planning period, each agency will continue to increase staff understanding of the factors influencing health outcomes.

Activity 1: Each agency will conduct a Health Outcomes staff in-service by March 31, 2012.

Note: An in-service outline and supporting resource materials developed by state WIC staff will be sent by July 1, 2011.

Implementation Plan and Timeline:

In January 2012 we will do an in-service on "Health Outcomes". The format and content will be determined when the in-service outline and supporting resource materials are received from State WIC.

Activity 2: Local agency staff will complete the new online Postpartum Nutrition Course by March 31, 2012.

Implementation Plan and Timeline:

All certifying staff will complete the new on-line Post-Partum Nutrition Course by March 31, 2012.

Activity 3: Identify your agency training supervisor(s) and projected staff quarterly in-service training dates and topics for FY 2011-2012. Complete and return Attachment A by May 1, 2011.

Agency Training Supervisor(s):

Jackie Lucas and Leslie Houghton

Attachment A

FY 2011-2012 WIC Nutrition Education Plan

WIC Staff Training Plan – 7/1/2011 through 6/30/2012

Agency:

Training Supervisor(s) and Credentials:

Staff Development Planned

Based on planned program initiatives, your program goals, or identified staff needs, what quarterly in-services and or continuing education are planned for existing staff? List the in-services and an objective for quarterly in-services that you plan for July 1, 2011 – June 30, 2012. State provided in-services, trainings and meetings can be included as appropriate.

Quarter	Month	In-Service Topic	In-Service Objective
1	May, June, July and August 2011 (see Goal 1, Activity 3)	Second Nutrition Ed Contact Review and Update	Review and update all certifying staff on options for second Nutrition Education Contact including classes and follow ups. Included will be a review of our updated High Risk Protocol and a review of the PCE skills and techniques used in our classes.
2	October 2011	*"Gallery Walk" of PCE skills and techniques for facilitating groups	Review and practice PCE skills and strategies used in teaching groups. Final format and content to be determined after State WIC supplies in-service outline and supporting resource materials.

3	December 2011	*"Gallery Walk" of PCE skills used in Breastfeeding counseling	Review and practice PCE skills and strategies used in breastfeeding counseling. Final format and content to be determined after State WIC supplies in-service outline and supporting resource materials.
4	February 2012	Health Outcomes: Connecting WIC participation with Health Outcomes	Format and content to be determined after State WIC supplies in-service outline and supporting resource materials.

***(see Goal 1, Activity 2 for explanation of "Gallery Walk")**

EVALUATION OF WIC NUTRITION EDUCATION PLAN FY 2010-2011

WIC Agency: Lane County

Person Completing Form: Leslie Houghton, MS, RD

Date: 03/14/2011 Phone: 541-682-4658

Return this form, attached to email to: sara.e.sloan@state.or.us by May 1, 2011

Please use the following evaluation criteria to assess the activities your agencies did for each Year One Objectives. If your agency was unable to complete an activity please indicate why.

Goal 1: Oregon WIC staff will continue to develop their knowledge, skills and abilities for providing quality participant centered services.

Year 1 Objective: During planning period, staff will learn and utilize participant centered education skills and strategies in group settings.

Activity 1: WIC Training Supervisors will complete the online Participant Centered Education Module by July 31, 2010.

Evaluation criteria: Please address the following questions in your response.

- Did your WIC Training Supervisor complete the module by July 31, 2010?
- Was the completion date entered into TWIST?

Response:

- Jackie Lucas, Leslie Houghton, Tammy Johnson and Leticia Ibarra completed the on-line PCE training by May 2010. We needed to complete it early so we could prepare to present the training to our certifiers as a group. The first group training date was June 15th 2010.
-Completion dates were entered into TWIST

Activity 2: WIC certifiers who participated in Oregon WIC Listens training 2008-2009 will pass the posttest of the Participant Centered Education e-Learning Modules by December 31,2010.

Evaluation criteria: Please address the following questions in your response.

- Did all certifiers who participated in Oregon WIC Listens training 2008-2009 pass the posttest of the Participant Centered Education e-Learning Modules by December 31, 2010?

Response:

Jackie Lucas, Leslie Houghton, Tammy Johnson and Leticia Ibarra held four training sessions in June and August for our entire certifying staff. Total training hours were about 11 hrs. We presented all ten on-line modules and did all the activities included with the modules. We developed scenarios and did small group role-playing covering all aspects and steps of "PCE" appointment. There was a trainer assigned to each group who observed the role-playing and gave feedback on improving PCE skills.

The tests were done individually and all certifiers passed by August 17th 2010.

Activity 3: Local agency staff will attend a regional Group Participant Centered training in the fall of 2010. The training will be especially valuable for WIC staff who led group nutrition education activities.

Evaluation criteria: Please address the following question in your response.

- Which staff from your agency attended a regional Group Participant Centered Education in the fall of 2010?
- How have those staff used the information they received at the training?

Response:
All certifying staff attended one of the Regional Group Participation Centered Education trainings in October 2010. Half of us went to Salem and half went to Roseburg. All of our certifying staff facilitate client education groups at our agency.

At an In-service in March 2011 we discussed ways that we have implemented PCE into the classes that we facilitate. Before the In-service certifiers were given a questionnaire to fill out on specific techniques, phrases and activities used and asked how this new approach is working. Below are listed changes that have made to classes to make them more participant centered:

Classroom set up:
Many people are using several round tables set up in the classroom to encourage sharing and talking of clients with each other. Small group discussions and activities encourage discussion and participation.
Sometimes in large classes a chevron or a semi-circle configuration is used for the chair set up. Even this small change makes it seem more informal and encourages participation.

Pair share, small group activities and sharing:
Many people are having small groups or pairs introduce themselves to each other. They will often be asked to tell each other something about themselves such as when they are due or something about their child/children. This gets them talking and participating. Sometimes groups are asked to prioritize what they would like to cover during the class or to share such things as why they are choosing to breastfeed. One of the activities that was mentioned involved putting table top cards on the table with quirky quotes about breastfeeding and discussing those. Another activity was putting pictures of babies on the table and asking them to decide what the baby was "saying" i.e. "I need a break" or "I'm hungry" etc. After the small group discussions they are asked to share with the larger group.

Other participant centered methods listed follow:

-Props are used such as the "babies" in the breastfeeding class.

-Summarizing to highlight key points and to keep the class on track is used.

-Affirmation of participation is used, even if information they share is incorrect or is simply not the message we would like leave them with. To correct information other participants are asked what they have heard or think about the issue i.e. "What have other people heard about this?" Then giving our message by saying "you might be surprised to know...."

-We are all using more open-ended questions and using the awkward pause to encourage them to answer. In bigger classes when tables are not used the whole group is asked open-ended questions.

-Sometimes fun questions are asked such as "what food is your favorite unhealthy snack?".

-In larger groups facilitators will go around the room and have each participant share something with the group, such as "how old is your baby" and "what foods have you fed her?".

Goal 2: Oregon WIC staff will improve breastfeeding support for women in the prenatal and post partum time period.

Year 1 Objective: During planning period, each agency will identify strategies to enhance their breastfeeding education, promotion and support.

Activity1: Each agency will continue to implement strategies identified on the checklist entitled "Supporting Breastfeeding through Oregon WIC Listens" by December 31, 2010.

Evaluation criteria: Please address the following questions in your response:

- What strengths and weaknesses were identified from your assessment?
- What strategies were identified to improve the support for breastfeeding exclusivity and duration in your agency?

Response:

There are truly too many strengths to list. Breastfeeding is a priority in our agency and we are always striving to improve. I have listed below what we have done to continue to improve our breastfeeding education, promotion and support.

-We continue to work on improving our connections with the community. We already have a very good working relationship with Sacred Heart Hospital. The lactation consultants at the hospital pick up several of our Lactina pumps weekly to loan to WIC clients who need them while still at the hospital.

In addition:
-Baby Connection and La Leche League (LLL) were invited and attended our Welcome Event open house in September 2010. (Baby Connection is a service of Birth to Three. They have meetings every week where nurses and lactation consultants weigh babies and give feeding help and breastfeeding support.)

- LLLwas contacted to see if we can restart having their meetings at our office, as was done in the past.

-The "Community Breastfeeding Resource" handout was updated.

-We established with the Maternal and Child Health Supervisor that all new Public Health Nurses (PHNs) will complete the Oregon WIC Breastfeeding Module. Elizabeth Lane, the newest PHN has completed the module. We have also offered to provide it to all established PHNs.

-Areas in which clients often need breastfeeding help were identified. New handouts were created to address these issues and to help them continue breastfeeding when problems arise. In addition others handouts were updated. The "Pumping Breast milk" handout was redone to be more participant centered. Phrases such as "Which of the following would you be willing to try" were used instead of the more traditional instructional wording. Several new handouts were created. An informative and attractive (colorful& glossy!) handout about ways to increase milk supply was created. It is participant centered and has places for the client to check or write in their personal choice or plan. There are additional inserts to this handout on more in-depth help on specific topics including a handout on fenugreek. New handouts were also created on hand expression, engorgement, asymmetrical latch and positioning.

-We changed our call back policy so almost all new moms are contacted shortly after birth to check on breastfeeding in those crucial first days. Support is given and questions are answered to help them get a good start and to encourage them in their efforts.

-Furniture and equipment were purchased to aid in breastfeeding intervention. Feeding syringes to be used to entice latch or used instead of a bottle when baby is very young, were purchased. Two chairs to be used in laid back nursing, 4 footstools for all nursing chairs and five "breastfriend" pillows for help with positioning were purchased.

-We now have 2 very comfortable private rooms for breastfeeding while at our office.

-New DVD's on tongue tie and new latch techniques were viewed by staff and added to our library for future staff training.

-Tammy Johnson, IBCLC attended the Gold 10 Conference to continue to improve her lactation management skills.

-Jackie Lucas and Leslie Houghton, our Registered Dietitians, attended the National WIC Association 2010 Nutrition and Breastfeeding Conference in San Diego, September the 21st through the 23rd 2010.

- We had our popular "Breastfeeding Tea" October 8th. We had one session for English speakers and one for Spanish speakers. This is our yearly celebration and recognition of breastfeeding mothers. There is always a lively discussion. We usually end up seeing people afterwards for help with breastfeeding and give out pumps.

Activity 2: Each local agency will implement components of the Prenatal Breastfeeding Class (currently in development by state staff) in their breastfeeding education activities by March 31, 2011.

No response needed. The Prenatal Breastfeeding Class is still in development.

Goal 3: Strengthen partnerships with organizations that serve WIC populations and provide nutrition and/or breastfeeding education.

Year 1 Objective: During planning period, each agency will identify organizations in their community that serve WIC participants and develop

strategies to strengthen partnerships with these organizations by offering opportunities for nutrition and/or breastfeeding education.

Activity 1: Each agency will invite partners that serve WIC participants and provide nutrition education to attend a regional group Participant Centered Education training fall 2010.

Evaluation criteria: Please address the following questions in your response.

- Which community partners did your agency invite to attend the Group PCE training fall of 2010?
- How do you feel partnerships with those agencies were enhanced?
- What went well and what would you do differently?

Response:

We invited the OSU Extension Nutrition Education (NEP) people to attend. They were very receptive but unfortunately were unable to attend either of the trainings. We have a close working partnership with NEP, as they teach a number of our classes. We were glad to be able to give them 2 copies of the DVD of the training. They were happy to be able to have this information as they are interested in making their classes more participant centered.

It was nice to have something concrete to give them on Participant Centered Education as we have been encouraging and working with them to become more participant centered in their classes.

The DVD was also offered to our PHNs as they do a lot of education while at home visits.

We will continue to offer any opportunities or materials that come up in the future to NEP and to the PHNs.

Activity 2: Each agency will invite community partners that provide breastfeeding education to WIC participants to attend a Breastfeeding Basics training and/or complete the online WIC Breastfeeding Module.

Evaluation criteria: Please address the following questions in your response.

- Which community partners did your agency invite to attend Breastfeeding Basics training and/or complete the online WIC Breastfeeding Module?
- How do you feel partnerships with those agencies were enhanced?
- What went well and what would you do differently?

Response only if you invited community partners to attend a Breastfeeding Basics training. The online WIC Breastfeeding Course is still in development.

-We established with the Maternal and Child Health Supervisor that all new PHNs will complete the Oregon WIC Breastfeeding Module. Elizabeth Lane, the newest PHN has completed the module. We have also offered to provide it to all established PHNs. We provided them with printed copies. After it is on-line it will be easier for others to access and we will likely offer it to other community partners such as Healthy Start and Baby Connections.

Goal 4: Oregon WIC staff will increase their understanding of the factors influencing health outcomes in order to provide quality nutrition education.

Year 1 Objective: During planning period, each agency will increase staff understanding of the factors influencing health outcomes.

Activity 1: Local agency staff will complete the new online Child Nutrition Module by June 30, 2011.

Evaluation Criteria: Please address the following questions in your response.

- Did/will the appropriate staff complete the new online Child Nutrition Module by June 30, 2011?
- Are the completion dates entered into TWIST?

Response:
All certifying staff will be completing the Child Nutrition Module by June 30th 2011. Staff will be doing the module on-line, individually, starting in March 2011. Certifying staff will take the on-line post test and the results will be given to a trainer for review. Missed answers and other questions will be discussed. After a certifier passes at least the 90% level it will be entered into TWIST by the trainer.

Activity 2: Identify your agency training supervisor(s) and projected staff in-service dates and topics for FY 2010-2011. Complete and return attachment A by May 1, 2011.

Evaluation criteria: Please use the table below to address the following question in your response.

- How did your staff in-services address the core areas of the CPA Competency Model (Policy 660, Appendix A)?
- What was the desired outcome of each in-service?

FY 2010-2011 WIC Staff In-services

In-Service Topic and Method of Training	Core Competencies Addressed	Desired Outcome
Group Completion of the PCE on-line Module Four sessions including roll playing and observations Started in June and completed in August of 2010	Core Competencies addressed: Communication, Critical Thinking, Nutrition Education, and Nutrition Assessment Process	To continue to increase staff's skills using Participant Centered Education while counseling clients. To do observations of certifiers while role playing various aspects of appointments so trainers could give feed back on what is going well and what could be done to be more effective with clients.
Developmental Screening for Certifiers i.e. who, when, where, and how to refer for further Developmental Screening. What to look for and how to do a quick prescreen. Debbie Figurski, PHN did this training November 2010.	Core Competencies: Critical Thinking, and Community Resources and Referral	To enable certifiers to be competent at and to feel more comfortable with, identifying and appropriately referring babies and child for Developmental Screening

Training on Vitamin D and new risks Training on Iodine and new risks Training on new prenatal weight gain recommendations and weight gain grids. These were done over 2 in-services in July and Nov 2010.	Core Competencies: Program Integrity, Nutrition Assessment Process, Nutrition Education, and Principles of Life-cycle Nutrition	To update staff on the changes in the recommendations for Vit D and Iodine and to update them on new WIC risks. Also, to update staff on the current prenatal weight gain recommendations and the new Prenatal Wt Gain Charts
Speakers from local community resources and agencies to whom we refer i.e. Charnelton Health Clinic (12/02/2010), Birth to Three (12/02/2010), Immunization (11/44/2010) Screening	Core Competencies: Critical Thinking, and Community Resources and Referrals	To enable certifiers to be competent at and comfortable with making appropriate referrals to community resources
"Trust: Working as a Team" presented to all staff. An exercise in identifying traits and skills that help people to work together as a team. Training done in January 2011.	Core Competencies: Communications, Program Integrity, and Multicultural Awareness	To increase our effectiveness in working together as a team and to better serve our clients, especially when stressed and when time is at a minimum (frequently)