

## Agenda Cover Memo

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AGENDA DATE: November 3, 2015

TO: Board of County Commissioners

FROM: Karen Gaffney, Assistant Director  
Department of Health & Human Services

DEPARTMENT: Health & Human Services

DESCRIPTION: SEMI-ANNUAL BOARD OF HEALTH REPORT

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This report to the Board of Health includes a discussion of several key issues related to Health & Human Services and the health of the community, followed by brief updates from each of the Department's nine divisions. The format is designed to target some of the most critical issues during this period, and of course staff will be happy to address any questions you might have related to these or other topics related to your role as the Local Board of Health. Since the Board of Health held a work session in September to discuss progress on the Community Health Improvement Plan, the regular semi-annual report will focus on some other core public health services provided to the community. Specifically, this report will provide information on community needs and services related to pregnant women and young children, as well as needs and services directed at containing the spread of communicable disease.

### **Women, Infants, and Children Nutrition Program:**

The Women, Infants, and Children (WIC) Program serves pregnant and postpartum women, infants and children under age 5 who have a low or moderately low income level and medical or nutritional risk conditions. Clients receive health screenings, supplemental foods and individualized nutrition education, as well as group classes on a wide variety of nutrition topics. High risk clients receive additional nutrition counseling with a Registered Dietitian. In 2014 Lane County WIC served 12,948 women, infants and children, and a total of \$4,899,781 was distributed in Lane County as a result of clients using WIC vouchers.

The program is currently maintaining a caseload of 8,092 clients per month. Of this total:

- 2,092 are pregnant and postpartum women
- This number includes 95 teen mothers who are age 18 and under
- **47%** of all pregnant women in Lane County are participating in the WIC program, which indicates the broad impact the program has on prenatal health and birth outcomes
- 1,881 infants between 0-12 months of age are enrolled
- Of the total number of families served, 88% are enrolled in Oregon Health Plan (OHP), and 66% are working families

Encouraging and supporting women to breastfeed their infants is high priority for WIC. In the most recent quarter, 96% of WIC mothers initiated breastfeeding. This is among the highest initiation rates in the state. In our county, 43% of WIC mothers maintain exclusive breastfeeding for at least 6 months. In addition to classes, individual appointments and providing breast pumps, WIC offers weekly drop-in sessions which have become well attended by mothers and babies seeking

assistance and support to maintain breastfeeding. The average age for infants attending the drop-in sessions is 6 days of age.

WIC maintains a partnership with the RiverBend Medical Center Lactation Consultant Team. As infants of WIC mothers are born in their Labor and Delivery unit, those with medical needs are able to receive loaned WIC breast pumps and education prior to leaving the hospital.

Smoking cessation interventions are provided through the Quit Tobacco In Pregnancy (QTIP) incentive program funded by Trillium. Since this program has been housed in the WIC clinic, QTIP is reaching a greater number of the county's pregnant women who smoke or have quit since becoming pregnant. For the period of January-September 2015: 154 women are enrolled in the QTIP Program; 65% of eligible participants have had at least one successful smoke free visit and received a cessation incentive.

There are also a number of challenges facing the program. Of the pregnant women who participate in WIC, 45% enroll during their first trimester of pregnancy. WIC research shows that the earlier in pregnancy a woman begins participating in WIC, birth outcomes improve significantly. Outreach efforts continue to focus on enrolling in WIC as early in pregnancy as possible. In addition, the program strives to find more ways to provide assistance to women in the early breastfeeding period in order to help resolve issues, encourage long term breastfeeding success, and promote the best possible healthy start for infants.

### **Maternal & Child Health Program:**

The Maternal and Child Health (MCH) Program has the following services (specific program descriptions are attached):

- Oregon Mother's Care—assisting pregnant women to apply for OHP and be connected to services
- Nurse home visiting programs including: Nurse Family Partnership, Maternity Case Management, Babies First!, and CaCoon.
- Healthy Families Oregon

In the last several years, the program has grown significantly as a result of becoming part of the scope of the Community Health Centers, as well as receiving a series of state expansion grants. The program includes a team of 12 nurse home visitors and an additional 10 home visitors located at Healthy Families subcontractors. Once all staff orientation is complete, the program will have a capacity to serve up to 360 families at a time with nurse home visits, expanding access to these services significantly over levels in prior years.

The Nurse Family Partnership (NFP) is an evidence-based home visiting program that is designed to begin serving women early in their pregnancy, and then continue to provide services until the child is two years old. Research on short and long term impacts of this program is significant, and bringing this program to Lane County has long been a goal in H&HS. This team launched in 2013, and in the past six months has seen the first cohort of graduations from this 2.5-year intensive program. It is exciting to see families completing the program and their successes due to participation in NFP.

In FFY 14-15 the MCH program received more than 1,600 referrals for nurse home visiting services from WIC, Trillium, Obstetric and Pediatric Provider's offices, hospitals, Department of Human Services, and Oregon Health Authority. WIC provides the largest percentage of referrals (62%), and the remainder come from community partners. The program provided nurse home visiting services to

288 pregnant women and 298 families with young children in FFY14-15 and delivered more than 2,450 home visits.

The community need for home visiting services is great and the expanded team is working hard to meet it. Recruitment for staff has been a challenge, and a particularly hard to fill position is the program's second Nurse Supervisor position. The very competitive market for nurses has also created challenges in filling all the nurse home visiting positions.

### **Communicable Disease Risks and Services**

The health of a community is dependent on a variety of quantifiable factors. Beyond the typical measures of mortality rates and life expectancy, the list of measurable factors includes health literacy, health behaviors, the economic environment, the physical environment, and social determinants such as income, education, and occupation.

Several recent disease outbreaks, both local and well beyond Lane County borders, reveal the health risks the local population will face in the coming months. They also highlight the limitations of the current public health infrastructure. The actual events listed below (as opposed to fanciful terrorist attacks with infectious agents such as smallpox) provide a sobering reminder of both the ongoing health risks local communities face, and the public health resources required to respond to such inevitable events. A few recommendations for our work into the future are listed after the examples.

#### ***1. Pertussis (i.e., whooping cough)***

By several measures, Oregon has the worst immunization rate of any U.S. state. Additionally, Lane County ranks amongst the worst of Oregon's 36 counties for both adult and childhood immunization rates (e.g., 3rd worst kindergarten rate according to Oregon Health Authority 2013 assessment).

While most pertussis cases fully recover after 2 - 3 months of mild to moderate misery, that is not always the case: A recent pertussis case in Yamhill County resulted in a 3 month hospitalization, including 75 days on a ventilator, and a hospital bill of \$1.5 million dollars for a single child (published data, Dr. Bill Koenig, Yamhill County Public Health department).

The recent massive pertussis outbreaks in the western U.S. (i.e., California 2010 & 2014, and Washington 2012 & 2015) strained Local and State public health departments to the breaking point. These nearby "infectious pressures," coupled with Oregon's unsatisfactory vaccination rates, put Lane County at significant risk—both the health of the residents, and the capacity of the Health Department.

#### ***2. Tuberculosis (TB)***

While Lane County continues to address a steady stream of TB cases, the staff in Benton County is currently responding to an ongoing, 10 month-long TB outbreak in homeless persons. Seven TB infections have been confirmed; DNA fingerprinting reveals they are linked, and two TB deaths have occurred, including the index case. Identified TB contacts included 35 in high-risk category, 50 in medium-risk category.

Between the demands of a large number of contact investigations, the nine months-long patient treatment protocol requiring directly observed therapy, and the extensive outreach to the clinical community and homeless camps, Benton County public health has been severely

strained in 2015 (verbal communication with Charlie Fautin, Benton Health Administrator and Bruce Thomson, Benton Health Officer). They have also hired additional staff (e.g., outreach worker and homeless navigator) to address the outbreak and to prevent further spread of TB to the broader community. Policy changes implemented in Benton County in response to this outbreak included at cold weather shelters, all persons must be TB screened by their third night or they will be turned away. Also, policy changes for TB screening are expected at other local facilities, including temporary tent camp sites.

Lane County's significant homeless population, coupled with "Rest Stops" and tent camps that do not have ongoing TB screening, places these communities at significant risk for a large and ongoing TB outbreak. As revealed by the current Benton County TB outbreak, response to such an outbreak is measured in months not days and requires both the reallocation of existing resources and the addition of new resources, such as staff.

### ***3. Mumps (2014 outbreak in Ohio and ongoing 2015 outbreak in Illinois)***

In 2013 the entire United States had a total of 438 mumps cases. In 2014 a mumps outbreak in central Ohio resulted in 484 confirmed cases. Of the 484 Ohio cases, 12 involved testicular disease, of which a small number will have infertility or decreased fertility for the rest of their lives. Four women had oophoritis. This infection of the ovaries can cause infertility or decreased fertility. One of the Ohio mumps cases had infection spread to the brain, with the unfortunate result of permanent deafness.

Illinois has an ongoing mumps outbreak at present, with 104 confirmed cases as of September 30, 2015. Affected sites in McLean County include Bloomington High School, University High School, Heartland Community College, Normal West High School, and Illinois State University. Full clinical data is, as yet, pending, but with an outbreak of that size there will likely be unfortunate outcomes similar to the Ohio mumps outbreak.

Lane County's troubling immunization rates, coupled with ongoing infectious pressures, place this community at significant risk for a large mumps outbreak. For similar reasons, Lane County is also at risk for a measles outbreak. A large measles or mumps outbreak, evolving over several months, would place extraordinary pressures on Public Health. Such an outbreak would not only cause pain, suffering, and long term disability, it would lead to prolonged deferral of select, non-emergent (but important) public health work and a requirement for additional resources to adequately address the outbreak.

### ***4. HIV and AIDS***

Lane County, with a 2014 population of 358,337 persons, had eight new HIV cases that year. Scott County, Indiana, with a population of 24,000, has had 181 new HIV cases in 2015 (through September 1, 2015). If Lane County had an HIV outbreak similar to Scott County, there would be 2,702 new cases. The Scott County cases are linked to diversion of a prescription opiate drug and shared needle use. Nearly every new HIV case in Scott County also has Hepatitis C infection. HIV is a lifelong infection with a lifetime medical cost of approximately \$550,000 per person (CDC, 2015 dollars). In Scott County the vast majority of cases are on Medicaid. As such, this cost will be borne principally by the state of Indiana and the local medical system, including safety net clinics and local public health. The Hepatitis C cases will also have a major cost: Either liver transplant later in life or the much discussed "\$80,000 pill"...that is, the new drug that can cure Hepatitis C but has a very large upfront cost.

Lane County and Oregon as a whole have troubling Hepatitis C statistics: Our death rate is 80% above the national average and our rate of new Hepatitis C infections is 50% above the national average.

Lane County, with a large IV drug using community estimated at ~3,000 persons, is clearly at risk for a scenario similar to Scott County. Such an outbreak would place extraordinary pressures on public health, the County Methadone program, and the broader clinical community.

Given the known risks in our community, as well as the examples of outbreaks in other communities, Lane County Public Health has pieced together a minimally adequate infrastructure across the multiple programs to secure the ability to respond. In this environment of very limited state and local resources, the system only works because of the skills and expertise that exist in staff across different H&HS programs. For instance, the Communicable Disease Team includes only four nurses, however, in the event of a serious outbreak the department will call upon nurses and other staff in programs such as Maternal Child Health and Environmental Health to put aside their regular work to assist in the investigation and response activities.

A key element for preventing the spread of these (and other) diseases is a strong surveillance effort that will identify cases of disease quickly and allow for a targeted and effective response. There are several opportunities for enhanced surveillance and prevention activities, some of which are currently underway, and others that could be opportunities for future work. Some examples include:

- **Collaborative work with the Lane County Jail regarding sexually transmitted infections:** After months of planning, Public Health and the Jail have launched a pilot project to voluntarily test and treat jail inmates for syphilis, gonorrhea, and chlamydia. The CDC recommends universal screening for these infections at correctional facility intake given the high prevalence among persons entering jails, and Lane County has a very high rate of STDs. This project launched at the end of October and is expected to run for a year to provide information to guide future programming.
- **Continued policy work to increase immunization rates:** In past legislative sessions, the Board has supported efforts to reduce the non-medical exemption rates and those rates have begun to decline. Given the historically low immunization rates in Oregon and Lane County, continued efforts to increase the number of people who are fully immunized will help protect the larger community from many preventable diseases.
- **Encouragement of screening at rest stops and other similar places:** Experience in other communities points to the high risk for tuberculosis and other infections to spread in environments such as rest stops and mass gatherings of people who are at high risk. In these situations, required screening for infections such as tuberculosis will help identify cases early, provide treatment, and contain the spread of disease.

# Nurse-Family Partnership Outcomes in Oregon

## July 2015



### Healthy Birth Outcomes

- 91% of NFP babies were born full-term in 2014
- 93% of NFP babies were born at a healthy weight ( $\Rightarrow$ 2500 g) in 2014

### Risky Behavior Reductions

- 14% reduction in cigarette smoking among NFP moms during pregnancy in 2014
- MIECHV NFP data shows a 58% reduction in child abuse rates between 2013 and 2014

### Healthy Babies

- 99% of NFP mothers report breastfeeding at birth, compared to 91% of Oregon WIC participants.
- Nearly 60% of NFP mothers continue to breastfeed at six months, compared to 43% of Oregon WIC participants.
- Immunization rates for two year-olds are more than 90% for NFP infants, compared to 74% statewide

### Empowered Moms

- 40% of mothers who entered the program without a diploma/GED have since earned one, and another 18% are working towards obtaining one



Sources: 2014 NFP data from the ETO outcomes report, PHD Vital Statistics, and the Oregon WIC Operational Data Store.



**STATE PROFILE 2014**



**NURSE-FAMILY PARTNERSHIP IN OREGON**

Nurse-Family Partnership (NFP) is an evidence-based, community health program that helps transform the lives of vulnerable mothers pregnant with their first child. Each mother served by NFP is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits that continue through her child's second birthday. Independent research proves that communities benefit from this relationship — every dollar invested in Nurse-Family Partnership can yield more than five dollars in return.

**NURSE-FAMILY PARTNERSHIP GOALS**

1. Improve pregnancy outcomes by helping women engage in good preventive health practices, including thorough prenatal care from their healthcare providers, improving their diets and reducing their use of cigarettes, alcohol and illegal substances;
2. Improve child health and development by helping parents provide responsible and competent care; and
3. Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work

**Positive Outcomes for Clients Served by Oregon's Nurse-Family Partnership**

**93%** of babies were born at a healthy weight - at or above 2500 g (5.5 lbs)

**91%** of babies were born full term

**95%** of mothers initiated breastfeeding and 49% continue to breastfeed at child age 6 months

**39%** of mothers who entered the program without a diploma/GED have since earned one, and another 18% are working toward obtaining one

Cumulative data as of June 30, 2014.

**CLIENT DEMOGRAPHICS**

**At intake**

Median age: 19

81% Unmarried

64% Medicaid recipients

Cumulative data as of June 30, 2014.

**Race**

75% White

9% Black or African-American

7% Multi-racial

4% Declined to self-identify

3% Asian

1% American Indian/Alaska Native

1% Native Hawaiian/Pacific Islander

**Ethnicity**

60% Non-Hispanic/Latina

39% Hispanic/Latina

1% Declined to self-identify

Data Oct. 1, 2010 - June 30, 2014.

All data is client self-identified.

ESTABLISHED: 1999  
FAMILIES SERVED: 3,033



In Oregon, Nurse-Family Partnership currently serves clients in nine counties: Crook, Deschutes, Douglas, Jefferson, Lane, Lincoln, Morrow, Multnomah and Umatilla.

**IMPLEMENTING AGENCY CONTEXT**

Nurse-Family Partnership in Oregon is operated individually by the local public health departments/districts in each county. The Multnomah Nurse-Family Partnership was the first site in Oregon. Implementation started in 1999 with four nurses and continues to expand. In Deschutes, Jefferson and Cook Counties, the program is operated under a tri-county partnership between the three county health departments. Umatilla and Morrow Counties operate under a similar partnership. NFP operates side-by-side with other home visiting programs provided by the health department and community organizations, creating a continuum of care for families in the community.

**FUNDING AND POLITICAL CONTEXT**

Varied funding sources support Nurse-Family Partnership in Oregon, including: Medicaid maternity case management, targeted case management, county general funds, private foundation grants, federal Maternal Child Health Block Grant funds, the federal Maternal, Infant and Early Childhood Home Visiting program and other federal grants.

**PUBLIC HEALTH PROGRAM WITH PROVEN AND MEASURABLE RESULTS**

**Societal Benefits**

Nurse-Family Partnership is a rare community health programs that is based on evidence from randomized, controlled trials – more than 37 years of research proves that it works. This evidence shows our clients – eligible first-time mothers – that if they follow the program and work with their nurse, they can transform their lives and the lives of their children.

**National Recognition**

- The RAND Corporation showed that every public health dollar policymakers and communities invest in Nurse-Family Partnership could realize more than five dollars in return for the highest-risk clients.
- The Partnership for America’s Economic Success found investments in early childhood programs, such as Nurse-Family Partnership, to be stronger investments than state business subsidies when viewed from a long-term, national perspective.



- The Center for the Study and Prevention of Violence reviewed over 650 programs with published research in peer-reviewed literature. Nurse-Family Partnership was found to be one of only 6% of the programs that clearly work, or even appear promising. The center fully supports and endorses NFP as one of its “Blueprints” programs. The project, Blueprints for Violence Prevention, identifies prevention and intervention programs that meet a strict scientific standard of program effectiveness.



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Denver, CO 80203-4304  
www.nursefamilypartnership.org

# Maternity Case Management (MCM)

## A Public Health Nurse Home Visiting Program

### Reduced Early Preterm Births for High Risk Pregnant Women

MCM is provided in many settings by different types of providers. These results reflect outcomes for the public health nurse home visiting program which operates out of local health departments with support from the state public health division.

#### Medicaid and MCM

There were 68,833 live Medicaid births from 2009 to 2012, excluding twins and births with unknown gestational age. Ten percent of women with a Medicaid-paid birth received MCM. Significantly more MCM clients were younger than 18 years old, lower income, Hispanic, Asian, Black/African American and Native American compared to pregnant Medicaid clients who did not receive MCM.

#### Study

Because MCM served a higher risk group, a matched sample of Medicaid clients who did not receive MCM was selected to control for sociodemographic differences. Clients were matched by pregnancy year, age, race, ethnicity, poverty, Medicaid enrollment length and urban or rural county. There were 5,405 MCM and 5,405 non-MCM study participants.

#### Results

MCM clients received an average of six MCM visits and had significantly higher rates of medical risk during pregnancy including mental health diagnoses, tobacco use, alcohol and drug abuse, but had the same risk for diabetes and hypertension.

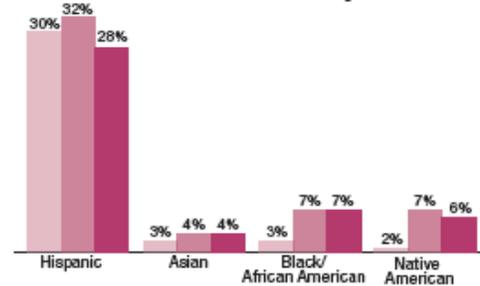
Results indicated that **MCM visits reduced early preterm delivery\* five percent per visit or 31 percent for clients with five or more visits**, controlling for adequate prenatal care, sociodemographic and medical risk factors.

#### MCM Potential Medicaid Cost Savings

MCM clients had fewer early preterm deliveries and their early preterm infants spent 10% fewer days in the NICU than preterm infants of Medicaid clients who did not receive MCM. The Institute of Medicine estimates the national average cost of a preterm birth is \$51,000 or \$3,000 per day in the NICU according to the Agency for Healthcare Research and Quality. The estimates suggest the potential for substantial Medicaid savings.

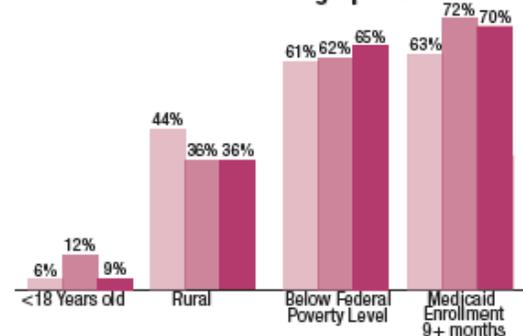
All Medicaid Births  
MCM Study Group  
Non-MCM Study Group

#### Race and Ethnicity



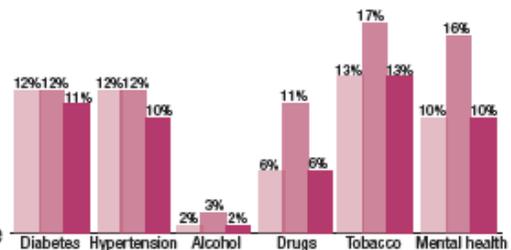
Chi-square significantly different at .05 for All Medicaid births and MCM Study Group

#### Other Sociodemographics



Chi-square significantly different at .05 for All Medicaid births and MCM Study Group

#### Medical Risk Factor



Alcohol, drugs, tobacco and mental health Chi-square significantly different at .05 Medicaid Claims Data

Note: A technical report provides detailed description of the research and analysis methods

#### At a glance:

Oregon Medicaid clients who received public health nurse home visits through MCM were less likely to deliver early preterm than Medicaid clients who did not receive these services.



\*Early Preterm: Less than 35 weeks gestation



Maternity Case Management  
971-673-0252

Information provided by:  
Oregon Health Authority;  
Department of Medical Assistance Programs  
Maternal and Child Health



# Oregon WIC 2014 Annual Report



**62%**

of women living outside of metro and urban areas used WIC during their pregnancy



**161,335**

Oregon women, infants and children were served by WIC



**\$64.7 million**

in WIC benefits spent at authorized grocery stores, pharmacies, farm stands and farmers' markets

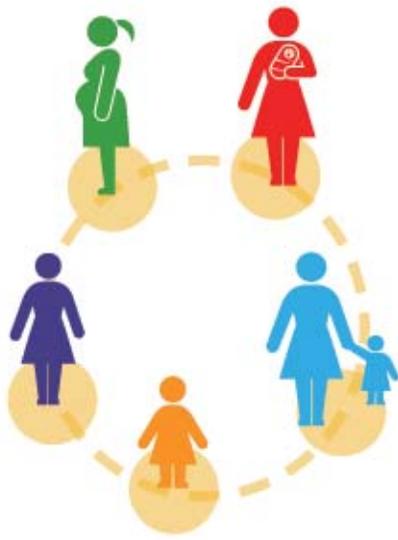
Oregon WIC Program  
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Suite 865  
Portland, OR 97232  
971-673-0040  
[www.healthoregon.org/wic](http://www.healthoregon.org/wic)

**\$479,261**

in sales to 699 farmers through the Oregon Farm Direct Nutrition Program



# Lifelong health begins with WIC



As the Oregon WIC Program moves into its forty-first year as a leader in public health nutrition, it is more evident than ever the impact that WIC has on lifelong health.

WIC services are based on four fundamental pillars that support critical areas of child development:

- ▶ Nourishing foods
- ▶ Nutrition education
- ▶ Community referrals
- ▶ Prenatal and breastfeeding support

Through these services, WIC continues to play an important role in laying the foundation for healthy communities now and in the future.

## ▶ Nourishing foods

WIC is unique among public health and food assistance programs in what it provides. Each item in WIC food packages is scientifically evaluated by a national panel of experts to determine whether it is a good source of the nutrients most commonly deficient in the diets of pregnant women and young children. This prescriptive food package provides fruits and vegetables, whole grains, and calcium and iron-rich foods, all of which play an important role in ensuring healthy pregnancies and preventing obesity, heart disease, diabetes and cancer.

## ▶ Community referrals

An essential pillar of WIC is the emphasis we put on connecting participants to community resources and making pivotal health-related referrals. WIC links families to education, health and social services and so much more.



### Our vision

Oregon families have the resources and knowledge to achieve optimal nutrition and lifelong health.

### Our mission

Assure the provision of premier public health nutrition services by providing leadership, guidance and resources to local WIC programs, retailers and partners.



## ► Nutrition education

Through nutrition education and counseling, our trained staff provide practical and tangible tools on topics such as healthy habits, family meals, parenting skills and more. Families also learn ways to increase physical activity, maximize their food dollars and support their child's growth and development.

## ► Prenatal and breastfeeding support

Research has demonstrated there are several sensitive periods where the foods we eat and our environment can create cellular changes in our body that may influence our future health. The nutrient dense foods WIC provides to pregnant women supports the critical stages of fetal development. Services in the postpartum period ensure that new mothers are provided with nutrients commonly depleted in pregnancy. WIC addresses another sensitive period by promoting exclusive breastfeeding. Cellular elements found only in breastmilk create a healthy mix of microbes in the infant's gut, which is linked to a healthier immune system.



## 2014 highlights

- Produce for Better Health Foundation recognized Oregon WIC as a **2014 Public Health Role Model**. This honor acknowledges our efforts to improve the American diet by increasing fruit and vegetable consumption.
- The Oregon WIC Advisory Board, in partnership with the Oregon Hunger Task Force, hosted an event in the State Capitol to **celebrate 40 years of providing healthy starts for families**. Legislators, partners and stakeholders joined in this celebration to bring awareness to WIC's positive health and economic impact, reach and value.
- WIC hosted a workshop for staff and partners called Bridges Out of Poverty, a transformational and comprehensive approach to addressing and reducing poverty. We have **formed a learning collaborative** to continue examining the impact services have on health equity and the relationships with our participants and partners.

## Return on WIC investment



For every dollar spent on a pregnant woman in WIC, up to \$4.21 is saved in Medicaid for her and her newborn baby because WIC reduces the risk for preterm birth and low birth-weight babies by 25% and 44%, respectively. -National WIC Association, *WIC: Solid Return on Investment While Reducing the Deficit, 2011*

### How WIC funds are spent



WIC is an equal opportunity program and employer. For information or if you need this in an alternate format, call 971-673-0040 or TTY 800-735-2900.

WIC is a program of the Oregon Health Authority.



### Family voices What our participants are saying

“WIC has been a very helpful program for me and my family. The staff at the Eugene office has been kind and considerate. The classes are informative and give real-life solutions to feeding your family healthy food on a budget. The Farm Direct Program is awesome. Having access to fresh, local produce is really nice. Another thing I really appreciate about the WIC program is their focus on breastfeeding. This program not only encourages you to breastfeed, but provides support, knowledge, and resources for those needing help with the breastfeeding process. WIC is an exceptional program. It has helped my family immensely.”

-Lane County

“WIC has been great at helping our family get through my pregnancy with less stress and now getting a breast pump helps baby get the best nutrition as I return to work.”

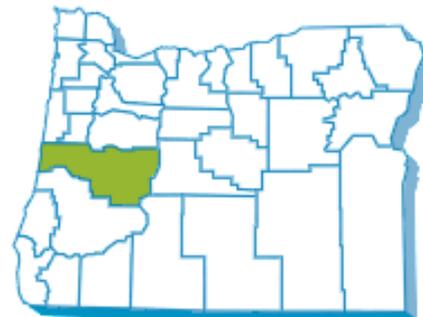
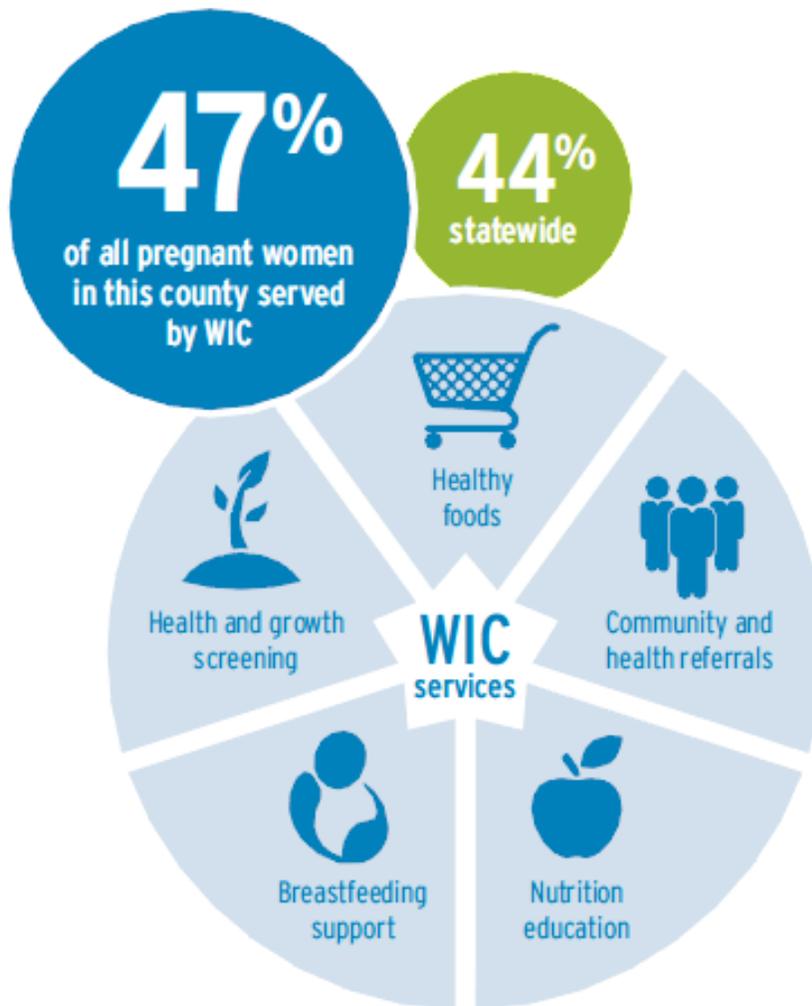
-Josephine County





# 2014 WIC Facts

## Lane County Health Department



# 12,948

Women, infants and children who participated in WIC

# 8,897

Infants and children under five

# 4,051

Pregnant, breastfeeding and post-partum women

# 5,272

WIC families served

### BREASTFEEDING

# 94%

WIC moms start out breastfeeding.

# 43%

WIC moms breastfed exclusively for six months.

National health organizations recommend that breastfeeding is the sole source of nutrition in the first 6 months.

# 66%

Working families



PUBLIC HEALTH DIVISION  
Nutrition & Health Screening Program for Women, Infants & Children

# 2014 WIC Facts

## Lane County Health Department

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### WIC-AUTHORIZED GROCERY STORES IN THIS COUNTY

53 WIC-authorized stores:

- 14 Independent stores
  - 28 Large regional or national chain stores
  - 6 Small chain stores
  - 5 Pharmacies
- 



### WIC AND FDNP-AUTHORIZED FARMERS IN THIS COUNTY

- 51 Farmers at 9 farmers' markets
  - 44 Farm stands
- 



### WIC CLINIC SITES

- Eugene
  - Cottage Grove
  - Florence
  - Oakridge
- 



For more details about these numbers, please visit:

<https://public.health.oregon.gov/HealthyPeopleFamilies/wic/Pages/annual.aspx>

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### Contact us

Lane Co. WIC: 541-682-4202  
Oregon WIC: 971-673-0040

TTY: 1-800-735-2900  
Web: [www.healthoregon.gov/wic](http://www.healthoregon.gov/wic)

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OHA 8784 Lane (04/2015)

## Administration

Administration is a division that provides administrative support to eight direct service divisions within Health & Human Services. This division includes: Fiscal Services, Contracts & Planning, Analytics, Public Information and Recruitment & Hiring.

Administration is in preparation for audit visits from two H&HS divisions' major grantors. These include a review with the Oregon Department of Human Services (Public Health - WIC), and an annual review with Oregon Housing & Community Services (Human Services Division), both scheduled for completion in October. Fiscal has started the preliminary work for FY16/17 budget preparation, which involves updating computer assignments by program for Information Services, along with employee position updates, benefits, and steps within the budget software.

Contracting staff are finishing up the current year contracts and now moving to reviewing changes to policies, procedures and internal process in response to the implementation of e-signature contract and changes to the Lane Manual Chapters 20 and 21.

The analytics team is focused on assisting Lane County Behavior Health (LCBH) in its transformation process. Highlights include the following:

- Leading a team that created a single integrated intake packet for Behavioral Health and Primary Care, streamlining the intake process and eliminating redundancy
- Managing a Behavioral Health/Primary Care integration project in which 130 clients receive fully integrated care coordination
- Leading a team that used lessons learned from the pilot project to create a detailed plan for scaling up integrated care to cover 400 or more adult clients, roughly half of all adult clients at LCBH

The department leadership team is working to build and strengthen our workforce to deliver our mission. One strategy is to focus on Recruitment and Retention. A recruitment workflow review was completed where a representative from each division and a Human Resources analyst reviewed current processes to identify difficulties, and problem solve to improve the recruitment workflow. Staff will work to implement the identified changes to improve efficiency and successfully fill open positions in less time.

To address retention, the H&HS Public Information Officer has created a video for new H&HS employees to better connect each person to the department and the work of each area.

## Behavioral Health

Lane County Behavioral Health (LCBH) is focused on meeting the needs of the highest risk individuals in the county. The key areas of this effort are access to care, corrections system interventions, and healthcare transformation.

**Access to Care:** LCBH has created a dedicated access team for adults seeking services. This new system was designed with ongoing consultation with the Mental Health Center of Denver. This dedicated work has enabled LCBH to create a stable and sustainable access team. The team utilizes an evidenced based screening tool which identifies the specific level-of-care required for the client. This assists in quickly getting a client into recovery-focused treatment that is matched to their particular needs and acuity. If the screening tool identifies a need for more intensive community based services (i.e., Assertive Community Treatment - ACT), the access team will make the referral immediately. LCBH collaborates with several community partners, notably Laurel Hill Center, to ensure LCBH clients get all their needs met.

**Corrections System Interventions:** The Jail Intercept Program at LCBH has been growing steadily. The program is focused on getting individuals with mental illnesses rapid access to care upon release from jail. The majority of these clients are homeless or marginally housed, and present with an array of complicated problems. The team is highly effective in engaging the clients and ensuring support for their recovery and wellness. This includes conducting outreach to homeless clients, linking to primary care, and comprehensive therapeutic interventions, including peer support, therapy, and psychiatry.

A key component of the Jail Intercept Program is providing crisis stabilization, including assistance with housing and income when possible. Staff conduct outreach to homeless clients and help with temporary housing in motels when possible. Referrals are made to Laurel Hill regularly for assistance with case management, respite beds and other supports that are not available at LCBH. The Jail Intercept Program also utilizes Peer Support services as a core component of the program, serving to engage individuals and assist with removing barriers to treatment. Additionally, the team has created bridges with court systems and is working to provide collaborative care across the county. Clinical interventions used in this program include Moral Reconciliation Therapy, an evidenced based group skills program, in addition to individual therapy, case management, and psychiatric services.

**Healthcare Transformation:** LCBH continues to do innovative work to integrate behavioral health and physical health care for LCBH clients. A plan has been developed to expand integrated care for all qualifying clients. This is the first step toward a fully integrated clinic that can respond quickly to the behavioral and physical health concerns of all clients receiving services. The clinic plans to expand integrated care as the program is able to hire additional primary care physicians. An additional key to fulfilling integration efforts is the December 2015 implementation of the Community Health Center's electronic medical record system (NextGen). This new system will allow providers to document in the same medical record, including shared care plans, and will serve to greatly improve collaborations on patient care.

LCBH has been highly successful in recruiting and hiring skilled clinical staff and managers. The recent focus has been on hiring psychiatrists, mental health specialists, and peer support specialists. This increase in staffing has given the clinic the ability to continue building team-based care and move forward key transformation efforts. It is clear that expanding integrated care, housing, and building more high-acuity teams will enable the county to meet the constantly emerging needs of those we serve.

## Clinical Financial Services

Clinical Financial Services (CFS) provides financial and computer support services to the Community Health Centers (CHC) and Behavioral Health Services (BHS) operating units. These services include ensuring accurate and timely insurance billing and collections, accounts receivable management, payments for services rendered, and clinical software support.

Key issues for this unit for the coming year include the following:

- **Clinical Finance Officer**

In July of 2015, Mike Barnhart was selected as the successful candidate to fill the CFO position vacated by Ron Hjelm when he was promoted to CEO. Mr. Barnhart had previously served as Lane County's Financial Services Manager and the Lane County Treasurer. Being new to CFS, his education and training in the financial operations of a Federally Qualified Health Center (FQHC) is top priority for the division.

- **Health Resources and Services Administration (HRSA) Site Visit**

CFS is playing a significant role in preparing for the HRSA site visit planned for December 2015. HRSA is the federal organization that grants the County's license to run an FQHC. CFS responsibilities will include updating all financial policies and procedures, making sure external audit documentation is available and up-to-date, and providing financial schedules and reports as required.

- **Addition of Delta Oaks Site**

The CFS billing team, supervised by Nelda Ortega, will take an integral role in helping the new Delta Oaks site become registered with Medicare and other applicable payers to ensure the CHC can bill for services rendered. Furthermore, with the addition of thousands of new patients at Delta Oaks, the CFS billing team plans to add one additional FTE in early 2016 to manage the increase in patient encounters.

- **Fiscal Accountability**

CFS continues to work closely with the CHC and BHS division managers to develop and provide operational financial reports and related statistical productivity analytics to provide accurate and timely information on program performance to assist them in their decisions.

- **Clinical Solutions Team**

The Clinical Solutions Team (CST) was moved from the CHC to CFS in recognition that CST supports both the CHC and BHS in the same manner as traditional CFS activities of billing and collecting. CST is the primary technical support and solutions group, supervised by Micah Brown, that supports the County's Practice Management (PM, or billing) and Electronic Health Record (EHR) systems.

- **NextGen Implementation at BHS**

In order to provide better coordinated care for our patients and clients, BHS will move off LC Cares, their legacy PM and EHR systems, and start using NextGen, the PM and EHR system used by the CHC. The transition is slated to be completed by the end of December 2015. Better coordination of care will become a reality when medical and mental health professionals can share the same database.

## **Community Health Centers**

Community Health Centers (CHC) of Lane County provides primary care at the Riverstone Clinic and Springfield High School in Springfield. CHC also operates the Charnelton Community Clinic, the Brookside Clinic, and the Lane County Behavioral Health primary care clinic in Eugene. CHC will also be opening a new clinic located in the Delta Oaks shopping center this November. In addition to primary care, the CHC offers prenatal care, dental prevention services, and integrated behavioral health services.

Key issues for the health center in the coming year include:

### **Increasing Access to Care**

CHC has successfully recruited a number of new primary care providers and behavioral health providers to our community. Also, the CHC has increased the number of providers to our community this fiscal year as a result of recruiting:

- 5 primary care physicians
- 4 nurse practitioners
- 3 behavioral health providers

CHC is working with TransforMed, the consulting arm of the American Academy of Family Practice, to assist in adjusting workflows, staff assignments, and scheduling processes. This project is designed to ensure utilization of staff to their highest potential, while streamlining and standardizing processes to improve program efficiency. These changes are necessary in order to enable the CHC to achieve more visits per hour of medical provider service, and thereby to increase primary care access to a greater number of community residents.

### **Opening the new Delta Oaks Clinic to Meet Community Needs for Primary Care Services**

CHC is on track with opening this new clinic on November 2<sup>nd</sup>. This clinic will enable the CHC to add six primary care providers and support staff to increase community access to medical care. The new clinic is expected to serve approximately 6,000 patients. The CHC has been very successful in recruiting new primary care providers to our community who will provide care at this site. Trillium Community Health Plan is providing \$1 million in financial assistance to support the development of this new clinic.

### **Meeting Clinic Performance Metrics**

The development of the Coordinated Care Organizations (CCOs) has increased the emphasis for providers to achieve specific clinical performance metrics that are tied to providing care to patients with Medicaid insurance. Medicare also has increased emphasis on clinical metrics for patients with this coverage. A key component of this emphasis on clinical improvement is incentive payments that are tied to achieving clinical metric targets. Medicaid, Medicare, and HRSA are all linking funding based on provider's performance to meeting identified clinical metrics. The CHC received \$1.8 million in this past fiscal year as a result of the CHC's performance related to these clinical metrics.

## **Developmental Disabilities Services**

Lane County Developmental Disabilities Services (DDS) is responsible for case management services for more than 1,500 children and adults with developmental disabilities living in Lane County. Lane County is the second largest county case management program in the state. Within DDS case management, services are separated into two distinct teams.

Services Coordinators on the adult comprehensive team are charged with the ongoing responsibility of monitoring clients' services in residential sites (foster care, group homes and supported living) and those who live in their family homes with in-home support plans. Services Coordinators monitor the health and safety of these vulnerable individuals and ensure their individual support plans are being followed.

The children's unit is responsible for monitoring the health and safety of children with a developmental disability who live in their family homes, foster care and other residential settings. Services for children who live in their family home focus on providing appropriate resources that support the child. Many children are now able to access in-home supports based on the new "K" Plan. Children who live in other settings are monitored by services coordinators to ensure they are receiving the supports outlined in their individual support plans.

Lane County DDS completes all intake and eligibility determination of individuals coming into services. Currently, DDS has a record-breaking 201 children and adults in intake at this time. The program also performs all re-determinations of current client eligibility at ages 7 or 9, 18 and/or 22. DDS also includes a specialized unit that acts as the designee of the State of Oregon in conducting investigations into allegations of abuse/neglect of adult individuals who are eligible for our services. Already in 2015 they have screened over 450 possible cases of abuse/neglect in Lane County.

### **Current highlights:**

- The February 2015 legislative session approved HB5026, which included funding the workload model at 95% for Community Developmental Disabilities Programs (CDDPs) statewide. Lane County DDS benefited from this increased funding to hire the following additional positions: nine new DD Specialists, one DD Abuse Investigator, one Professional/Technical Supervisor, one Management Analyst, and three Office Assistants. All of these positions allow the program to provide a higher level of customer service and enhance the quality to the whole division.
- Creation of a High School Transition case management team. These DD Specialists will specialize in working with young adults who are transitioning out of high school to the workforce. This team will work on employment and independent living goals with the individuals served.
- Implementation of a new electronic health record (EHR) – CaseWorthy. This new EHR will allow for better data tracking and quality assurance reporting. CaseWorthy is a much more robust and efficient tool for accessing information to the individuals served. A newly hired management analyst is leading this implementation.
- Staff are preparing for the state audit slated for August of 2016. All processes and policies are being updated in order to get in line with all the new Oregon Administrative Rules (OARs).
- The Community First Choice Option "K" Plan was implemented in Oregon on July 1, 2013. It allows Oregon to provide home and community-based services and supports while receiving an additional six percent in federal Medicaid funding. Lane County DDS continues to provide these enhanced services for eligible individuals. Currently, Lane County DDS is providing in-home services to approximately 750 children and adults. DDS had a successful implementation of systems transition from a crisis driven system to a system of choice and resources.

## Human Services Division

**Energy Services:** In the program year just ended, Lane County received \$2.5 million in federal Low Income Home Energy Assistance (LIHEAP) funding which served 8,137 low-income households with energy assistance, crisis energy assistance, and 62 households with crisis heat system repair or replacement. Partnerships with EWEB, Emerald PUD, NW Natural and Pacific Power in the upcoming program year will allow Lane County to serve an additional 5,000 households with energy assistance and energy conservation education.

**Housing and Human Services:** The Poverty and Homeless Board (PHB) has been operating for more than a year and has tackled key issues including the implementation of homeless winter funding strategies, a committee to develop a 50 unit housing first program for chronically homeless singles and creating a three year strategic plan. The Homeless Coordinated Entry System (CE) for singles and families, piloted with families only in August 2012, is now fully operational for both populations. Ten “front door” non-profit agencies screen and assess client needs, determine program eligibility and priority for homeless housing programs. HSD’s \$2,759,258 HUD Continuum of Care (CoC) grant submission was awarded to fund 14 projects serving homeless adults, youth and families for 2015.

**Family Mediation:** Historically the Family Mediation program has provided domestic relations mediation and parent education services. In the past year the program has added two other family-court related services: supervised parenting time and custody evaluations. Family Mediation serves approximately 1,600 parents each year through parent education and mediation orientation services, 700 parents with direct mediation services, 50 families with supervised parenting, and other families with custody evaluation services.

**Veteran Services:** In the current calendar year, Veteran Services has helped 761 clients receive positive decisions from the Veterans Administration (VA) which resulted in \$583,615 in new monthly benefits and \$5,475,249 in one-time retroactive benefits. With the end of the state 2014-15 fiscal year, the Veteran Extended Outreach Grant came to a close. Veteran Services met all of the individual grant metrics – increasing public presentations and increasing the number of veterans who were helped to apply for VA health care enrollment. Furthermore, during the grant period the number of new clients increased by nearly 20% over the applicable “baseline” period. Additionally, Veteran Services is doing more claim development work pre-filing to ensure that the VA will expedite handling under their “Fully Developed Claim” process.

**Workforce Services:** In 2014-2015, the Workforce Investment Act (WIA) Program placed 146 people in On-the-Job Training with employers; average wage during this time period was \$15.02/hour. The WIA program awarded 44 training scholarships and 62 students were served in the AARP Foundation funded services. A new four-week series to provide basic computer training at Work Source Lane was developed and delivered to customers. Rapid Response services were provided to 20 employers and over 300 affected employees (laid off due to staff reductions and/or closing of businesses). A total of 596 Jobs clients were served in Work Experience. 3,907 Jobs clients were served in Job Search training, and 416 were placed in Jobs Plus placements with employers.

## Public Health

Public Health promotes and protects the public's health and prevents disease in Lane County through our core programs and in collaboration with our community partners. In September, Lane County Public Health joined PeaceHealth, United Way and Trillium to conduct an assessment of our community's larger public health system, one of four assessments that together comprise the Community Health Needs Assessment for 2016-2019. The public health system includes government public health as well as other public- and private-sector organizations whose activities have significant consequences for the health of the community. Many of these local organizations were represented at the assessment. Among the key findings were that organizational collaborations and community partnerships to advance health priorities in Lane County are strong and participants perceived that the public health system has robust plans in place to investigate and respond to emergencies. Opportunities for improvement identified by this group included leveraging technology to make community health data and analysis available more broadly to stakeholders and community members. The new Community Health Assessment and Community Health Improvement Plan will be completed in April 2016.

Following passage of House Bill 3100, Public Health has also been collaborating with other local and state public health leaders in developing definitions for the core programs and foundational capabilities necessary to deliver essential public health services in Oregon. The broad assessment and planning work locally gives a strong foundation for continuous quality improvement and for aligning local work with national public health standards. As a division, Public Health is preparing to apply for national accreditation with the Public Health Accreditation Board in 2016.

Highlights from the core Public Health programs:

- The Emergency Preparedness (EP), Environmental Health (EH), and Communicable Disease (CD) programs develop plans to rapidly mount an effective response to an emergency and to prevent, investigate, report and respond to outbreaks or the spread of communicable disease. Work continues with the University of Oregon on the ongoing Meningococcal outbreak. CD is also monitoring other disease cases and trends, including an increase in pertussis, and is providing seasonal flu immunizations to Lane County staff and the public.
- Environmental Health inspects food and lodging facilities, temporary events, pools, day cares and schools as well as rural drinking water systems. Inspection information is now available on a searchable map online:
  - <https://lcmaps.lanecounty.org/LaneCountyMaps/RestaurantInspection/index.html>
- The Women, Infants, & Children (WIC) program is preparing for "eWIC" – beginning in January, benefits will be issued through electronic debit cards. The change will improve security and create a more seamless and convenient experience for grocery store personnel and WIC clients.
- The Maternal Child Health (MCH) program has expanded its home visiting team to twelve nurses to meet the needs of pregnant women and new mothers who require extra support to be healthy and to be good parents. MCH was also awarded competitive funding to continue the Healthy Families Oregon program in cooperation with the Relief Nursery and Parenting Now!
- The Office of Health Systems of the Oregon Health Authority awarded the Prevention Program funding to coordinate another conference on mental health promotion in 2016. Through the same office, Public Health was asked to participate in the Partnership for Success Initiative, which provides 4 years of funding to focus on the prevention of underage drinking and prescription drug abuse.

## **Trillium Behavioral Health**

Lane County contracted with Trillium Community Health Plan as a risk-bearing partner in the Coordinated Care Organization (CCO). Agate has now been purchased by Centene, a Fortune 500 corporation. Lane County Health & Human Services expects the contract for Trillium Behavioral Health (TBH) to continue to manage the behavioral health system for Centene and to remain as essential members of Trillium committees and the CCO management team.

Staff do not expect the purchase of Trillium by Centene to change the role of the County in managing the behavioral health benefit for the CCO. In all meetings where the transition is being discussed, Centene employees speak extremely positively about the role and performance of TBH in the management of the Oregon Health Plan (OHP) benefit and their intent to support this partnership.

TBH Behavioral Health Care Coordinator's (BHCC) role is changing with implementation changes associated with the Centene purchase, integration with CCO medical management staff, implementation of NCQA procedural changes, and the reality of a larger member pool. Additional Care Coordination positions have been created, although recruitment remains a challenge within the program, currently having three vacant positions. There is an increased need for documentation of member interactions, especially around complaints and grievances.

Centene has also purchased HealthNet, a large insurance plan with many members on the west coast. When this purchase closes, it is likely that Trillium Medicare products will expand to include up to 11,000 new Medicare members in Lane County and may incorporate an additional 50,000 members statewide. If TBH participates in the oversight of behavioral health services for these new Medicare members, as planned, this will require significant planning and expansion of staff.

Trillium has terminated the state contract to manage the Public Employees' Benefit Board (PEBB) health insurance plan as there were not a sufficient number of enrollees.

Trillium applied for National Committee for Quality Assurance (NCQA) certification and developed policies and implemented new procedures to meet standards. Trillium passed the review and received a three year NCQA certification.

The county received state funding for two care coordination specialists to work with older adults with behavioral health concerns. These positions were assigned to TBH and active recruitment is underway to fill the new vacancies. TBH has temporarily assigned one program supervisor to this program half time and has filled one care coordination position. TBH will develop a strategic plan for engaging system service providers to develop a more coordinated and efficient delivery system.

TBH staff is actively leading the community effort to transform the delivery model and integrate physical and behavioral health. The TBH medical director is providing significant support to the eight funded projects, has created an active learning community, and is addressing alternative payment approaches.

TBH continues to provide active community leadership in the System of Care associated with the wraparound services built into the CCO benefit and included in the Trillium contract. Currently 120 families are receiving wraparound services.

## **Youth Services**

### **Administration**

Youth Services leadership continues to support the mission of creating safer communities through crime free youth through a variety of initiatives. Implementation and sustainability of evidence-based practices to most efficiently and effectively serve high risk youth and their families referred through our law enforcement partners. Youth Services works to develop and sustain partnerships at the national, state, and local level that will help reach division goals. Examples of these partnerships include the University of Cincinnati Corrections Institute with Effective Practices in Community Supervision and Core Correctional Practices, Georgetown University's Center for Juvenile Justice Reform, addressing disproportionate minority contact, prevention, and working with Child Welfare partners to serve families that are both high risk and high need in our community. Working with local political leaders and the Oregon State Legislature, Youth Services was able to secure start-up funding for a shelter and assessment center on the Serbu campus to serve high need youth in Lane County, filling a critical gap in service delivery.

### **Educating Adjudicated Youth on the Serbu Campus**

The MLK Education Center, in collaboration with Lane Education Service District, is now serving youth in detention, the Phoenix Program, and our community-based alternative education program. Through this expanded collaborative effort, all educational services on the campus are now provided through one administration, expanding educational offerings, and aligning youth with needed services based on risk level and individualized needs. MLK serves secondary students who currently have an active case with Lane County Youth Services. The program is a collaboration between Lane County Youth Services, Lane ESD, and many more local, state, and federal agencies. MLK offers wrap-around services and support to youth who have experienced multiple interruptions in traditional school placements. Our mission continues to be providing our students with opportunities to develop skills needed to be successful in school, work and our community. MLK focuses on job skills education and offers on-site vocational programs to all youth. These programs offer students hands-on learning about careers and vocational paths. Currently Youth Services offers courses and training in Culinary Arts, Horticulture, and Outside Community Placements.

### **Community Supervision**

The Crossover Youth Practice Model formally launched in September, which is designed to improve the coordination and collaborative service planning for youth in both the Juvenile Justice and Department of Human Services Child Welfare Systems, reducing system dependence and penetration. Youth Services continues efforts to secure funding through Title IV-E, seeking reimbursement for services currently offered through this funding stream. Disproportionate minority contact continues to be a point of focus to Youth Services, and research is currently being done to determine the effectiveness of tools utilized including the program services matrix and the risk assessment instrument at the point of intake.

### **Secure Programs**

Secure programs works to prioritize community safety while balancing the individualized needs of youth in the program, by providing services for sanctions, assessment, and skill building. The Phoenix Program has recently expanded services to include services for females and drug and alcohol treatment.