LANE COUNTY PUBLIC HEALTH AUTHORITY

COMPREHENSIVE PLAN

SUBMITTED TO OREGON HEALTH DIVISION MAY 2010

FOR FISCAL YEAR 2010/2011

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I. Executive Summary

The Comprehensive Plan submitted for FY 2010-2011 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 Department of Human Services, 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 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 year long process which enriched the product and understanding of what public health's role is in a community. Overarching goals in the plan are: 1. The community experiences accessible, aligned and adaptable public health services; 2. Public Health is valued and supported by the community; 3. Public Health provides leadership in creating a Healthy Community; 4. Maintain a competent public health workforce; 5. Public Health continuously improves processes, programs and practices; and 6. Public Health has resources to achieve identified goals. Each of these goals is linked to the ten essential public health services that guide and inform the strategic directions of Lane County Public Health.

Additionally, we have worked with a county team in the planning and design of a newly remodeled Lane County Public Health facility. A significant amount of time has gone into the effort with a move anticipated July 2010. Several programs within the department will be in the building which will provide the opportunity for more efficient delivery of services to our community. Public Health staff has been involved in the design of improved work processes and clinic operation.

II. Assessment

1. 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 2009 estimated population prepared by the Population Research Center of Portland State University for Lane County was 347,690, continuing it as the fourth largest Oregon county by population. The county has seen a steady growth over many years (2008: 345,880, 2007: 343,591, 2005: 335,180, 2000: 322,959). 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 22.4% (state was 23.2%)
- OHCS Poverty Report 2008 (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 2008 (2007 status) shows 71% of the population living in poverty are 18-64 year olds.
- Percentage of persons 65 years old and over was 14.3% (state was 13.2%)
- OHCS Poverty Report 2008 (2007 status) shows 8% of the population living in poverty are people 65 years and older.
- Lane County population reported in 2008 was 89% White with 2.8% Asian, 1.9% American Indian/Alaska Native, and 1.1% Black; 0.2% Native Hawaiian Islander and Other Pacific; additionally, 5.9% of the population identified as Hispanic or Latino origin.
- The level of educational achievement included 89.7% of the adult population as high school graduates and 27.9% of the population having a bachelor's degree or higher.
- The U.S. Census Bureau for 2006-2008 notes the median household income as $44,180 compared $52,175 in the U.S. The same report notes 9.6% families live below the poverty level and 13.2% individuals live below the poverty level.
- The unemployment rate in February 2010 was 11.4 compared to the state 10.5. The rate In January 2009 was 11.8 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 2007 was 78%. The overall state rate was 70% for 2007. Lane County Public Health serves 1% of this age population while the private medical community provides the rest of the immunizations.
- Continued increase in gonorrhea cases (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 chlamydia cases (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 rolling rate of 10-17 year olds for January-December 2009 was 7.3 compared to the state rate of 8.6.
- Teen pregnancy rolling rate of 15-17 year olds for January-December 2009 was 17.1 compared to state rate of 21.8.
- 25.3% of Lane County adults are obese (24.1% statewide) and another 35.3% (36.3% statewide) are overweight.
- BRFSS 2004-2007 age-adjusted data shows 6% of Lane County adults have diabetes (6.5% statewide), 25.8% have high blood pressure (24.8% statewide), 31.6% have high blood cholesterol (32.3% statewide), 10.0% have asthma (9.9% statewide), 3.2% have coronary heart disease (3.6% statewide).
- BRFSS 2004-2007 age-adjusted data shows 19.9% Lane County adults smoke cigarettes compared to 18.7% statewide
- 9% of 8th graders report smoking cigarettes compared to 9% in Oregon.
- 14% of 11th graders report smoking cigarettes compared to 17% in Oregon.
- 4% of 8th graders report using smokeless tobacco compared to 5% in Oregon.
- 9% of 11th graders report using smokeless tobacco compared to 12% in Oregon.
- 20% of adults report smoking cigarettes compared to 19% statewide.
- 22% of all deaths in one year in Lane County are due to tobacco use.
- 14% pregnant women report smoking cigarettes while pregnant, compared to 12% statewide.
- Fetal Infant Mortality rate 2000-2004 for Lane County was 9.4. Oregon's rate was 8.0. Lane County's "Reference Group" rate was 8.4 compared to the U.S. "Reference Group" rate of 5.8.

In 2009, there were 3,550 births to Lane County residents, down from 3,778 in 2008. 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 2009 the percentage was 8.2%.

In 2009, 61.3% 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 74.0% in 2009. The downturn in the economy and the increase in poverty and homelessness may contribute to decreased early access to care.

In 2009, percentage of births with low birth weight in Lane County was 6.5%. 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 is higher than the national average, the state, and the three other large Oregon counties by population (Multnomah, Clackamas and Washington). State vital statistics for the five year period of 2000 – 2004 indicate that the overall fetal-infant mortality rate for Lane County was 9.4 as compared to the nation at 9.1 and Oregon at 8.0. Lane County Public Health continues to facilitate a number of coordinated efforts to address this serious problem.

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 2 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.

In response to the issues that were identified, HBHC members developed a list of proposed community actions to address issues that had been identified including: education and outreach to high schools to promote healthy preconceptual behaviors; enhanced tobacco education and cessation efforts; the development of a user-friendly electronic risk screening tool with algorithm and referral drop downs for health care providers; outreach to health care providers to promote use of electronic risk screening tool; earned and purchased media to promote safe infant sleep; co-sleepers for low income families to ensure safer sleep; “this side up” onesies for all newborns to get the message out; SIDS and safe sleep training for nurses working in labor, delivery, nurseries; dedicated staff time to work to reduce fetal-infant mortality; continues data analysis; and process and content evaluation.

2. **Adequacy of Local Public Health Services**

During FY 08/09, our local public health budget was substantially reduced within the county general fund category due to decreased timber funds. The reduction was felt mostly in the communicable disease team. We were reduced to three full time communicable disease nurses with responsibility for surveillance and investigation of reportable communicable diseases, sexually transmitted disease clinic and investigation, tuberculosis control, immunization clinic and community and provider education and immunization accountability, as well as preparedness functions for an estimated county population of 343,591 people. In addition, we have reduced one position in our administrative support, eliminated our lab tech position and reduced the Public Health Officer hours.

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 continues to maintain 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 10/11, but one which does not address all the public health needs of our community. We had attempted for FY 10/11 to create a new position within our Chronic Disease Prevention Team but the County Administrator has not included the position in his recommended budget to the Lane County Budget Committee. The Budget Committee has not begun their deliberations yet on the budget so there still might be a chance for the position. Many competing positions are in the mix as well as the concern that within two years, Lane County will not be receiving any timber funds, 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 continues to provide a quality 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. Although services are currently maintained at approximately 98% of assigned caseload, the WIC Program could potentially take on more clients. The state WIC Program has also indicated that the Lane County caseload could be increased. Our budget could accommodate increased use of temporary staff for additional clients appointments, however, the lack of office spaces precludes this possibility. With the move to the new building, it may be possible to begin increasing caseload sometime after August 2010.

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 (see organizational chart for staffing). 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. On July 1, 2010, EH will add a 0.6 FTE Public Health Educator (PHE) to the team. The PHE will work on preparedness and CD case investigations, especially those related to norovirus, including outbreaks in nursing homes and large gatherings. Environmental Health program has completed its first successful year of expanded services of inspections for the State Drinking Water Program.

3. **Provision of Five Basic Services (ORS 431.416)**

Communicable disease

Epidemiology

For Lane County Public Health, as for the rest of the country, the overriding focus for public health communicable disease epidemiology work in 2009 was about the surveillance and reporting, prevention, education, and community partner collaboration around the H1N1 influenza pandemic. LCPH has been working on this since H1N1 was first reported in the country, in Oregon, and in Lane County in May, 2009. Surveillance activity continues.

Officially, Lane County had 202 reported hospitalizations and 12 deaths due to lab confirmed influenza between September 1st, 2009 and March 31st, 2010. All of the deaths were in people 25 years of age or older, while the reported hospitalizations included 28 children up to age 4 years and 36 children from age 5 to 18 years. Lane County's rate of hospitalization for lab confirmed influenza stands at 58.4/100,000 population, the forth highest rate in the state. The death rate stands at 3.5/100,000 population, tying with Benton County for an eighth place ranking. Lane County had a significant number of critically ill hospitalized cases with long stays in intensive care units in local hospitals including a pregnant woman and others during the summer of 2009.

In May, when H1N1 was first identified and before the case definition for reportable influenza was finalized, cases were identified in local schools which led to the temporary closing and cleaning of several. Schools, hospitals, outpatient clinics, police and emergency responders and other community partners were deeply involved with LCPH on prevention efforts long before H1N1 vaccine became available in October of 2009.

LCPH is evaluating our H1N1 response and planning for either a "third wave" or the occurrence of another large communicable disease outbreak. Planning will proceed to address communicable disease nurse orientation for both normal work activities, the maintenance of a pool of initially trained and credentialed volunteer and extra help nurses, and updating primary epidemiological just-in time training for nurses to assist in outbreak and large event situations. We will be building on the success of our H1N1 nurse recruiting and training effort in 2009. Also, a forth full time communicable disease nurse will be joining our staff in May of 2010 which will significantly expand our capacity.

A major undertaking for the communicable disease program will be the integration of the ORPHEUS database for disease reporting. The program is already installed. We have had our initial state orientation. We will continue to work to optimize the effectiveness of this reporting tool. We will also be working with Peace Health to coordinate secure LCPH access to the hospital databases, Theradoc and Carecast, for reportable communicable diseases entered in to their system.

Finally, LCPH will continue to attend to the reporting, surveillance, and investigation requirements for required Oregon reportable communicable diseases.

<u>Sexually Transmitted Diseases</u>

LCPH is currently transitioning from the Multnomah County STD Data Base to the statewide ORPHEUS database. We anticipate that this will facilitate confidential communication and morbidity reporting with the state STD program as well as with other counties.

Lane County chlamydia cases have continued to climb with 1,268 being reported in 2009, with an incidence rate of 365.9 per 100,000 population. The incidence of chlamydia in Lane County is the 4th highest in the state behind Multnomah, Marion and Jefferson counties. Gonorrhea cases continue to be elevated at 139 for 2009, with an

incidence rate of 39.5 per 100,000. Lane County's reported incidence of gonorrhea is second only to Multnomah County's. Syphilis counts remain low, with a total of 5 cases in Lane County in 2009.

While it appears that these numbers represent a true increase in the incidence of reportable STDs in Lane County, it should be noted that Planned Parenthood in Lane County received funding to promote, test, and treat more individuals for STDs in 2009.

LCPH's ability to provide STD screening appointments was hampered in 2009 by the diversion of staff resources to H1N1 related activities. At the height of the H1N1 response, during the fall and winter of 2009/2010, LCPH partnered with the Community Health Centers of Lane County (CHCLC) who examined, tested, and treated people with symptoms of STDs upon referral from LCPH. The CHCLC also tested and treated contacts of reportable STDs who were referred by LCPH or the Disease Information Specialist.

LCPH will be addressing the rise in STDs by increasing the number of appointments available for clients in our office. A new communicable disease nurse will be joining our team and beginning her training in May, 2010. LCPH nurses will continue to perform the essential lab functions that were added when the Lab Technician position was eliminated.

Tuberculosis

Lane County continues to be a low incidence area for active tuberculosis. The official count of verified tuberculosis cases for 2009 was 1 with an incidence of 0.3 cases per 100,000 population. However, 2 other cases, which required substantial TB investigation and case management work over several months, were not included in the official count due to residency issues. In addition, LCPH provided initial tuberculosis investigation and treatment for several clients, in whom mycobacterium tuberculosis was subsequently ruled out.

LCPH is currently following 3 cases of active disease. Case investigation for one of the newest cases is underway and will include home, community, and worksite review. None of the current cases is from the homeless population. One case is foreign born, one is related to a case from another state, and the third case moved here from another state after his initial diagnosis.

LCPH continues to provide twice yearly inspection of the UV lights that were installed at the Eugene Mission. Unified public health efforts and collaboration with the shelter is yielding positive results in preventing the spread of tuberculosis in our community.

LCPH will continue to provide ongoing B2 Waiver tuberculosis evaluation and follow-up for those referred from immigration.

Immunizations

An essential report from the state, the AFIX Report, is not yet available to LCPH. As a

result, some LCPH plans for the Immunization Program will follow under separate cover, once the report become available for our analysis and planning.

The LCPH Immunization Program was markedly affected by the H1N1 immunization effort. The effort crossed public health programs including Preparedness and Communicable Disease. Other aspects of this effort are covered in the appropriate sections of this plan. Between October, 2009 and April 1st, 2010, LCPH directly provided over 19,000 H1N1 immunizations at the following clinic sites: at LCPH by appointment and drop-in; at large off-site LCPH H1N1 immunization events such as fairground clinics; at schools not immunized by school based health centers or school nursing staff; at facilities for underserved or at-risk populations including group homes, day facilities, and assisted living facilities; at community events such as Project Homeless Connect; at shopping malls. LCPH trained 79 extra help and volunteer nurses and 1 doctor to provide these H1N1 immunizations.

In addition to the direct LCPH H1N1 immunization effort, LCPH provided H1N1 vaccine support and allocation to 90 community partners throughout Lane County including hospitals, outpatient clinics, pharmacies, private medical providers whose clients are within the targeted increased risk populations such as those serving children and pregnant women, and school based health clinics. By the end of March 2010, over 106,000 doses of various formulations of H1N1 vaccine were allocated and distributed within Lane County.

LCPH anticipates that the H1N1 flu immunization effort will continue, in a limited form, into the next fiscal year and flu season. We are continuing our efforts to identify and immunize vulnerable populations with limited access to services. We are prepared to ramp up H1N1 immunization efforts based on influenza surveillance information and direction from the state and CDC.

LCPH reviewed 53,483 school immunization records for completeness for the 2009/2010 school year for all children in pubic and private schools, and in preschools and certified day care facilities. We worked with 158 school and 144 children's' facilities to address omissions in immunization records. On February 3rd, 2010, school exclusion letters were issued for 2,522 students. Of these, 407 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.

It is particularly remarkable that this effort was so successful this year, in that the same team of vaccinating nurses and school immunization coordinating staff was simultaneously running the H1N1 community immunization work. In calendar year 2009, LCPH directly provided 3,188 non-flu immunizations. Our delegate clinics provided 7,052 in the same timeframe. With the scheduled hiring of a new communicable disease nurse in May, 2010 and the planned effort to keep current recently trained extra help and volunteer nursing staff, LCPH appears well positioned to

be able to sustain a robust community immunization program as well as to retain the capacity to rapidly increase our efforts should the need arise again.

Another measurement that the School Immunization Review process addressed is the religious exemption rates in all schools, pre-schools, and certified day care centers in Lane County. In 2009, the overall RE rate for these Lane County facilities was 5.4%, representing 2,903 children.

In the spring of 2009, LCPH undertook a survey of parents who chose religious exemption for their child's school immunization requirement in large schools with excess (>10%) RE rates. A survey was also conducted of family practitioners and pediatricians to determine their experience, concerns, and approaches with such families. The survey is complete and under separate cover. Based on the results of this effort, LCPH is developing an immunization program objective around decreasing RE rates in certified daycares and preschools. This objective and the tasks associated with it will be formalized in the Immunization Annual Plan due after the County receives the AFIX report from the state.

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.

Beginning in August of 2010, the provision of some services will shift, due to the logistics of moving and providing LCPH services in a new building. LCPH has been providing 10 pack needle exchange services at our front counter as well as drop-box availability for used syringes behind the public health annex. After the move, the drop-box will continue to be available. However, LCPH is working to shift direct provision of 10 packs to HIV Alliance, which already provides needle exchange services both at their main office and in the community. In 2009 there were 4,743 client encounters at LCPH for the 10 pack services.

HIV Counseling Testing and Referral Services (CTRS) will continue to be provided by appointment and, when possible, for client drop-in at the new building. In 2009 LCPH provided these services in-house and also at Willamette Family Treatment Center (WFTC). Outreach and testing was also added at Buckley Detox & Sobering Center. Wednesday afternoons will 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 will 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, injections drug users (IDU), and sex partners of people in these populations. In 2009 LCPH and its subcontracted partner together exceeded that goal every month and provided a total of 1,067 HIV tests. Program plans for HIV testing in fiscal year 2011 are being finalized now. LCPH estimates that we will provide 400 HIV tests during fiscal year 2011. 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 410.

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. LCPH and HIV Alliance are collaborating to train a nurse volunteer to, once again, be able to provide hepatitis A and B immunizations at needle exchange van sites.

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.)

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 430 low income pregnant women

were served in 2009. 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 2009 MCH nurses provided home visiting for 778 unduplicated clients. Of these, 373 received maternity case management, 295 received Babies First!, and 86 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 10/11 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. (See Family Planning Annual Plan attached.)

Collection and Reporting of Health Statistics: Lane County Public Health provides statistical information to Oregon DHS/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, 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 2009: full service and limited service food facility (939), bed and breakfast (13), mobile units (138), commissaries and warehouses (35), temporary restaurants (1000), pools/spas (322), traveler's accommodations (113), RV parks (71), and organizational camps (13), for a total of 2,644. The total in 2008 was 2,554 and in 2007 was 2,465. In addition to license facility inspections, EH staff completed 159 daycare inspections and 275 school/summer food program inspections. The EH and CD teams work closely together as needed to ensure safe food and tourist accommodations. In 2009, the following are some of the violations found upon general inspections: improper holding temperatures (468), contaminated equipment (305), and poor personal hygiene (102). 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 28,685 food handler cards, of those 1,557 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.

4. Adequacy of Other Services

Primary Health Care:

In regards to primary health care a division within the Lane County Department of Health and Human Services as 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 Place Building, the building that all public health services will be moving to late July/August 2010. Having a primary care clinic in the same building as public health services will be most helpful to the people we serve and will provide for continued coordination of services between the two divisions. As of July 1, 2006, the department's family planning clinic was moved to the CHC from public health. Due to a reduction in county general funds to the family planning program, administration decided that it was necessary to make this change. The positive side of the change is that more families have been able to access primary health care and establish a medical home. One of our nurse supervisors continues to work closely with the FQHC nurse supervisor regarding family planning, immunization and sexually transmitted disease questions.

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 and Communicable Disease Response Program ("PHP 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 PHP 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 2010-11, the following objectives have been identified for the PHP 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. The following plans are slated for update:
    a. Pandemic Influenza Response
    b. Vaccine and antiviral distribution
    c. Strategic National Stockpile request, receipt, and management
2. Develop plans to describe the functions, roles, and procedures necessary to address the following hazards:
    a. foodborne outbreaks
    b. food defense
    c. water quality protection and provision
    d. vector borne illnesses
    e. Earthquake and Tsunami
3. In conjunction with hospital and health care preparedness planning underway in the local healthcare community, actively support the development of medical surge plans, including plans to support the deployment of Federal Medical Stations locally.
4. Implement the first year of the Lane County Public Health 2010-2013 exercise and training program, which will include at least two exercises that increase in complexity and adhere to Homeland Security Exercise and Evaluation Program (HSEEP) guidelines.
5. Participate in the nationally recognized Project Public Health Ready accreditation program. During this fiscal year this will include conducting a gap assessment,

identifying a timeline, establishing priorities and progressing towards accreditation based upon the developed project plan.

6. Provide technical support to the Lane County Vulnerable Populations Emergency Preparedness Coalition and assist with actions identified within the coalition's work plan.
7. 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.
  2. Rising STD rates – gonorrhea, chlamydia.
  3. IRIS is fully functional and integrated with ALERT – historical data input is completed.
  4. Countywide immune rates for 24-35 month olds (4-3-1; 3-3-1) needs ongoing assessment.
  5. Continued integration and training of applicable preparedness activities and staff with CD program.
  6. Continued immunization delegate support (have ten delegate agencies).
  7. High religious exemption rates for immunizations in certain populations. (See Immunization Action Report)
  8. Continue H1N1 Pandemic work.

- **TB Control Measures:**

  Goals:
  1. Prevention of TB outbreaks at homeless shelter.
  2. Reduce infectiousness of TB in homeless shelter.
  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.

  Activities:
  1. Twice yearly inspection of the ultra-violet light system at a homeless shelter (system was installed fall of 2003.)
  2. Provide homeless shelter staff education to screen symptoms.
  3. Maintain up to date reporting to state to show required performance measures for Program Element 03 are being met.

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 in homeless shelter as noted in Program Element 03 of IGA with DHS.

- **STD Control Measures**:

Goals:

1. Prevent and control spread of STDs in Lane County.
2. Meet program requirements in Program Element
3. Address STD investigations locally

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 by hiring and training another communicable disease nurse
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. 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 STD exam appointment opportunities will return to 2008 levels (prior to 2009 H1N1 effort)
6. 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.

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

  Goals:

  1. CD team members will understand Incident Command Structure (ICS), their roles during preparedness exercises and events. Will be NIMS compliant.
  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.

  Activities:

  1. CD/Preparedness staff will participate in monthly staff meeting.
  2. Complete mandatory trainings according to the Public Health Training Plan for staff positions.
  3. Participate with Preparedness Coordinator and Supervisor in drafting and reviewing plans.
  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. Evaluation of exercises, events will be done in a “Hot Wash” and After Action Reports with the CD team.
  3. Review training records to verify trainings are completed.

- Continue to focus on increasing overall immunization rates of 24-35 month 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 IRIS.
  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)
  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 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.
5. Transition LCPH direct needle exchange activities to HIV Alliance site.
6. Direct provision of LCPH services such as STD exams and treatment and/or referrals such as HIV case management per IGA with DHS.

Evaluation:

1. HIV program staff will maintain data as required by DHS 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.

Tobacco Prevention Program Objectives:

- By June 2011, share local chronic disease prevalence data with the county's Public Health Administrator and develop a plan to jointly present data and information regarding the link between chronic diseases and tobacco use/exposure and lack of physical activity/poor nutrition with the county's Board of Health/Board of County Commissioners
- 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 2011, Lane County Health & Human Services will develop, adopt, promote, implement and enforce a tobacco free property policy for all H&HS worksites
- By June 2011, Lane County Human Resource Department will have developed and implemented a policy to regularly promote the Free & Clear cessation

program included in the county health benefit package to all employees and retirees.

- By June 2011, Lane County TPEP staff will have responded to all complaints of violation of the Smokefree Workplace Law according to the protocol specified in the IGA and the Memorandum of Understanding with the City of Eugene.
- By June 2011, the Housing and Community Services Agency of Lane County (HACSA) will have adopted and implemented a smokefree policy for all HACSA owned and/or managed properties (1,410 units).
- By June 2011, TPEP staff will have engaged in a minimum of 5 educational/outreach meetings/events attended by multi-unit housing stakeholders outside of the public housing realm (property management companies, affordable housing owners/managers, private housing landlords etc.)
- By June 2011, the Lane Community College tobacco policy (which currently bans tobacco use "in the core of the campus" but allows tobacco use in parking lots – takes effect Fall 2010) will be improved to come in line with best practices (100% tobacco free campus).

Healthy Communities Program objectives:

- By June 2011, share local chronic disease prevalence data with the county's Public Health Administrator and develop a plan to jointly present data and information regarding the link between chronic diseases and tobacco use/exposure & lack of physical activity/poor nutrition with the county's Board of Health/Board of County Commissioners
- 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 2011, promote all local Living Well & Tomando Control de su Salud courses available to the "Well Group"/worksite wellness coordinators coalition & follow up with individual coordinators to encourage and support their efforts to promote employee attendance
- By June 2011, identify at least four organizations whose mission is compatible to the provision of Living Well and/or Tomando, share information regarding Living Well with identified organizations and connect them to training opportunities
- By June 2011, work with the local Living Well Program Coordinator (Peace Health employee) and other local Living Well collaborating partners to document current outreach efforts and develop and implement a plan to expand efforts to encourage PeaceHealth clinical and hospital staff to refer appropriate patients to Living Well, Tomando and the Quitline
- By June 2011, work with the local Living Well Coordinator and other local partners to identify and establish relationships with at least four new influential local champions for the program
- By June 2011, if an AFEP training will be offered in Lane County, work with Met Group and the Oregon Arthritis Program on the local Arthritis Pain Reliever Campaign

- By June 2011, Lane County Health & Human Services will develop, adopt, promote, implement and enforce a tobacco free property policy for all H&HS worksites
- By June 2011, Lane County Health & Human Services will develop, adopt, promote, implement and enforce one or more of the policy objectives included in the Governor's Wellness Initiative (GWI)
- By June 2011, Lane County Human Resource Department will have developed and implemented a policy to regularly promote Free & Clear cessation program included in the county health benefit package, the Oregon Tobacco Quitline, and Living Well/Tomando to all employees and retirees
- By June 2011, one or more schools in Springfield School District will implement and enforce the District policy to fully comply with ORS 336.423/HB2650
- By June 2011, Lane County Public Health will participate in a collaborative CBPR pilot project focused on two convenience/corner stores located in low-income areas in the cities of Eugene and Springfield with the Lane Coalition for Healthy Active Youth (LCHAY), the Willamette Food & Farm Coalition, Shelter Care, Oregon Research Institute (ORI), and Dari Mart to: learn how neighbors in the pilot areas make use of food sources currently available and in what ways available food sources influence purchasing behavior; understand how residents cope with limited access to nutritious foods; influence store owners and managers' decision-making regarding product mix, pricing, placement and promotion; increase availability of healthier, affordable options at two pilot stores; develop policy recommendations to improve access to healthier, affordable foods in underserved communities

Parent and Child Health

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

Current condition or problem:

1. First trimester prenatal care has improved for Lane County in 2009 to 74.0% from 71.6% in 2007. The state declined to 71.4% in 2009 from 78.4% in 2007. 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 DHS 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. Local OMC brochure was developed in 2009; updates will occur as necessary and printing of brochure continued.
4. Continue collecting and submitting client data quarterly to state as noted in OMC Program Elements in the IGA with DHS.
5. 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.

Evaluation:

1. At this time OMC staff is tracking client information manually and looking into electronic system for tracking. In the meantime, OMC staff will continue to send the 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. Printed materials provided throughout community and as requested by client and community agencies. Excel spreadsheet will be maintained to track 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 state and national average and higher than other large counties in Oregon for all population groups. Initial data indicates 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. PRAMS (Pregnancy Risk Monitoring System Data) indicates that Lane County has a higher rate of binge drinking and of smoking before and after pregnancy than the state. Alcohol and tobacco use are markers for illicit drug use. Babies First! services are provided for infants and young children at significant risk of poor health or developmental outcomes.
3. Collaborative partnerships with health providers and other service agencies have resulted in continued referrals for MCH services.
4. 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.
5. PHNs provide Babies First services for infants and young children at significant risk of poor health or developmental outcomes.

6. 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.
7. 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 DHS 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 DHS IGA.)
5. Provide nurse home visiting support for families who have experienced a SIDS death. (As noted in Program Element 42 of DHS 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 DHS 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.

Family Planning

Current condition or problem:

1. We have increased the number of Family Planning (FP) clients receiving Plan B for future use from 12.1% in 2008 to 23% in 2009 (we do not have the data for FY 2010), but we can do better. As noted in program element 41 of the DHS IGA we are to provide a broad range of contraceptive methods.
2. Male FP Services are not provided by Community Health Centers (CHC) of Lane County. 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. Continue to increase the number of clients receiving Plan B to 50%.
2. Educate new medical staff about Plan B so every provider, nurse and CMA is asking about Plan B at every FP visit.
3. Educate incoming providers and other staff to offer Plan B to all FP clients.
4. Put up Plan B signs and posters in the exam rooms of the new clinic.
5. Establish a male family planning program.
    a. General informational session of Title X and FPEP
    b. Specific review of male family planning policy with the providers working at the two CHC high school sites.
    c. Gather appropriate forms for health history, physical exam and other education pieces.
    d. Begin male services.

Evaluation:

1. Information on Plan B was completed at the general Title X and FPEP orientation meeting March 2010.
2. Visual inspection of rooms to ensure posters are displayed. Ultimately our CVR data will indicate a continued increase in the number of FP clients receiving Plan B for future use.
3. Title X and FPEP information session for staff was completed March 2010.

4. Male FP protocol has been e-mailed to providers in clinics for review March 24, 2010.
5. Male FP forms were generated and sent to providers in clinic for review March 23, 2010.
6. Male visits can be evaluated using CVR data.

Progress on Goals/Activities for FY 10 (this section is required by state office to be included in the annual plan).

1. FY 10 Goal/Objective: Increase the number of male Family Planning visits.
   Progress on Activities: No progress was made on this goal and we will make this a goal for this coming year. We have two high school clinics but the staffing has been erratic at best. We are opening a new clinic mid-February and most management time has been devoted to this. The staff is being shifted around again for the new clinic. Once staff movement has settled down, we will focus again on adding male services.
2. FY 10 Goal/Objective: Increase the amount of Plan B provided to FP clients.
   Progress on Activities: As stated above, we have increased the amount of Plan B we are providing to our clients, but we can do better. Based on our opening of another clinic site and the consequent addition of providers, increasing the amount of Plan B provided will be a goal for the 2011 Annual Plan.
3. Progress on Title X Expansion Funds:
   a. Increase the range of contraceptive methods on your formulary and/or the available number of high-end methods (IUDs and Implanon): We provide IUDs and Implanon to our clients.
   b. Increase the hours of your clinic(s), the number of staff available to see clients, the number of days services are available or offer walk-in appointments: We were planning on adding a dedicated Saturday Family Planning clinic once/month as RiverStone is open two Saturdays/month. A small amount of Family Planning visits are provided by the staff on Saturdays, but the clinic is basically urgent/primary care. This was delayed due to staffing difficulties. We will attempt to start one Saturday/month in March or April 2010.

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. 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. Two 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.

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. Complete 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.

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 Division 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.

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.
2. Testing and licensing for food handlers will be provided five days a week in the central office. On-line testing is also available. (As required by SFP IGA)
3. Environmental Health staff will maintain files on all epidemiological investigations and send documented summaries to Oregon Health Division as required.
4. EHS personnel will provide health education to staff of licensed facilities while conducting inspections – comments will be noted in facility file as needed. Environmental Health Specialists will also provide health education to the public as requests are made as required by the SFP IGA.
5. A log will be kept of all animal bites (includes incident, victim name and follow-up completed). Information will be provided to Oregon Health Division as required.
6. A summary log including resolution will continue to be kept of all citizen complaints regarding licensed facilities as required by the SFP IGA.
7. EH staff will enter and monitor program output and outcome data as part of the countywide performance measure tracking.
8. EH staff will conduct all inspection, investigation and educational responsibilities associated with the State Drinking Water Program as required by the SDW IGA.
9. EH staff will properly enter all data into the State Drinking Water data collection system (SDWIS) as required by the SDW IGA.

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 at the Annex Building. 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 is 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 well as ability to bill for services (e.g. Babies First, Maternity Case Management).
5. Staff continue to answer many inquiries regarding obtaining birth certificates over six months of age from the state.

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.

Health Information and Referral Services:

Current condition or problem:

Lane County Public Health provides health information and referral services five days a week in the Eugene office. Information and referral services are also provided in the WIC office and Environmental Health Office located in Eugene.

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, services provided through written and oral format and 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.

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 Division to provide this program in Lane County.

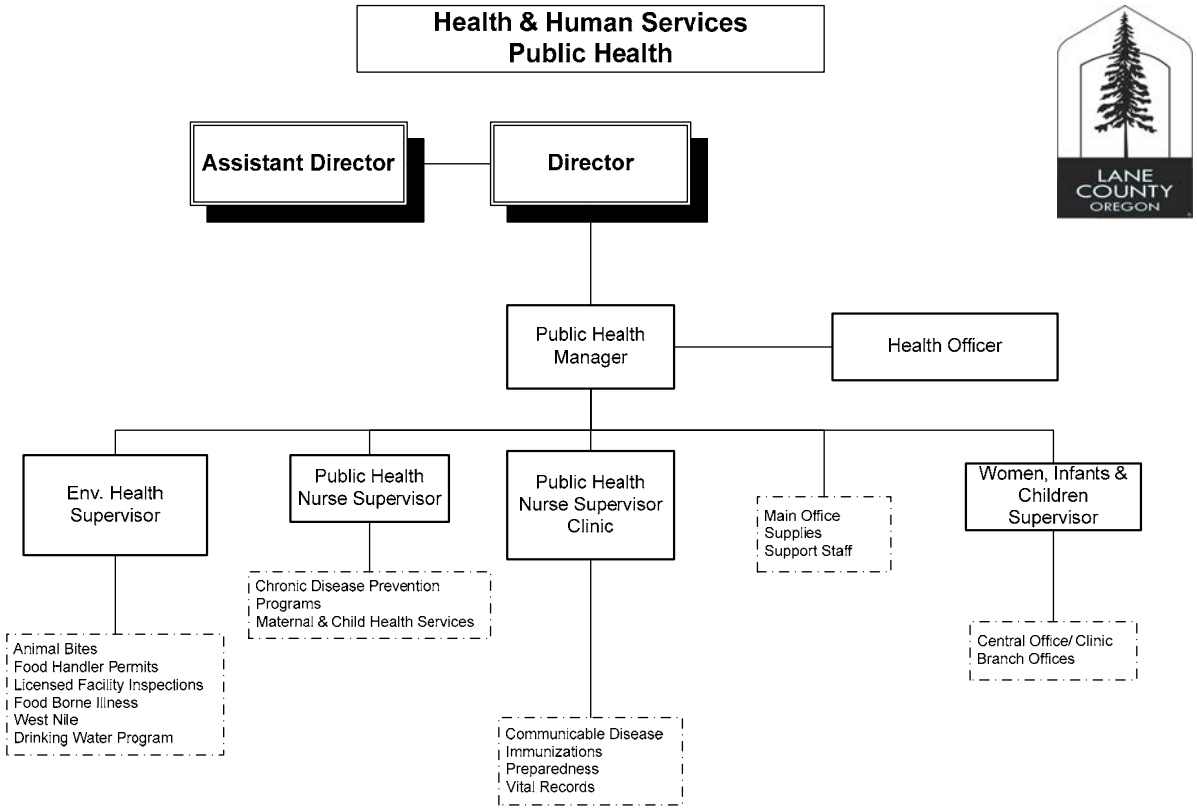
IV. Additional Requirements

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, such as our several discussions held this past year regarding menu labeling and herbicide spraying. With the assistance from our County Counsel, the Board of Health developed better understanding of their authority to pursue and set policy at the local level to ensure improved community health. These 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 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 2010, the committee has identified the following major themes/work proposed to the commissioners: drinking water program, review of EPA-approved particulate matter standards, review of the cumulative downwind health impact of pollen and pollution, disposal of expired medications, food safety in schools, chronic disease prevention, environmental health in general.

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.



Public Health Department Structure
Last Update: 03/09

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 09/10. 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.

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 17 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. Continued strong local community relationships are vital to further the work in chronic disease prevention.

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 us to work on. A Fetal Infant Mortality Review (FIMR) has been established in our county. 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 __X_ No __ 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	County	Date

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.

EVALUATION OF WIC NUTRITION EDUCATION PLAN FY 2009-2010

WIC Agency: Lane County
Person Completing Form: Leslie Houghton, RD
Date: 3/3/2010 Phone: 541-682-4658

Return this form, attached to email to: sara.e.sloan@state.or.us by May 1, 2010

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

Goal 1: Oregon WIC staff will have the knowledge to provide quality nutrition education.

Year 3 Objective: During planning period, staff will be able to work with participants to select the food package that is the most appropriate for their individual needs.

Activity 1: Staff will complete the appropriate sections of the new Food Package module by December 31, 2009.

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

- Did staff complete the module by December 31, 2009?
- Were completion dates entered into TWIST?

Response:
We did an in-service on assigning the new food packages at an all-staff meeting on July 8th 2009. The training included an over-view of changes, new screens in TWIST, and case studies on appropriate food package assignments viewed together. TWIST practice on computers was done in small groups with trainers who had attended the Special Users session at the WIC state meeting. We used materials provided by State WIC to practice on several case studies.

All staff completed the new Food Package module by 12/18/2009 except one person who was out on medical leave. She completed the module by 2/24/2010. Completion dates were entered into TWIST.

Activity 2: Staff will receive training in the basics of interpreting infant feeding cues in order to better support participants with infant feeding, breastfeeding education and to provide anticipatory guidance when implementing the new WIC food packages by December 31, 2009.

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

- How were staff who did not attend the 2009 WIC Statewide Meeting trained on the topic of infant feeding cues?
- How has your agency incorporated the infant cues information into 'front desk', one-on-one, and/or group interactions with participants?

Response:
O*ur staff R.D.'s attended both sessions done by Jane Heinig at the Statewide WIC conference i.e. " The Secrets of Baby Behavior " and "Translating Infant Cues into the Group Setting". Using that information and information from the new Infant Feeding Module an in-service was given for all certifying staff on August 6th 2009.*

Handouts on infant feeding cues were also distributed. We discussed which of these could be used in appointments and how they could be incorporated into effective counseling. One of the handouts discussed and passed out to staff was "7 Secrets of Baby Behavior"; another was" A Parent's guide to Baby Talk".

This information has also been incorporated into our classes including "Baby Bonding" "Preparation for Breastfeeding", "Breastfeeding Chat" and "Intro to solids".

Activity 3: Each local agency will review and revise as necessary their nutrition education lesson plans and written education materials to assure consistency with the Key Nutrition Messages and changes with the new WIC food packages by August 1, 2009.

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

- Were nutrition education lesson plans and written materials reviewed and revised?
- What changes, if any, were made?

Our two staff RDs review Nutrition Education materials on an ongoing basis. In one-on-one training of staff and at staff meetings we regularly review appropriate handouts to use for counseling. We also regularly review material and either revise or discard out-dated materials.

We have, for example, made sure that all materials conform to the guidelines out-lined in the "Feed Me!" handouts based on the new infant feeding guidelines. We have distributed new handouts relating to the changes in the food packages including the information on whole wheat and the type of milk offered to clients.

Up to date, one-on-one training with our staff is ongoing as well. Much of our certifying staff this year has been new and inexperienced. Training on appropriate counseling, both issues and techniques, continues almost daily. In staff meetings we have addressed a myriad of training subjects including answering difficult questions such as no formula for the first month for breastfeeding babies, the benefits of whole grains, the change to low fat milk for women and children over two years, infant feeding cues , participant centered counseling and how to discuss growth.

Activity 4: Identify your agency training supervisor(s) and staff in-service dates and topics for FY 2009-2010.

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 2009-2010 WIC Staff In-services

In-Service Topic and Method of Training	Core Competencies Addressed	Desired Outcome
Example: Providing Advice Facilitated discussion during October 2009 staff meeting using the Continuing Education materials from Oregon WIC Listens.	**Example:** This in-service addressed several competencies in the core areas of Communication, Critical Thinking and Nutrition Education	**Example:** One desired outcome of this in-service is for staff to feel more comfortable asking permission before giving advice. Another desired outcome is for staff to use the Explore/Offer/Explore technique more consistently.

In-service One: *Food Assignment Training, July 8, 2009*

The training included an over-view of changes, new screens in TWIST, and case studies on appropriate food package assignments viewed together. TWIST practice on computers was done in small groups with trainers who had attended the Special Users session at the WIC state meeting. We used materials provided by State WIC to practice on several case studies.

We wanted to give staff a basic understanding and some hands on experience with case studies so they could feel confident to use it in real situations in the clinic when the change in food packages and in TWIST screens went into effect.

In-Service Two: *Infant Feeding Cues, August 6, 2009*

Our staff RDs attended both sessions done by Jane Heinig at the Statewide WIC conference i.e. " The Secrets of Baby Behavior " and "Translating Infant Cues into the Group Setting". Using that information and information from the new Infant Feeding Module an in-service was given for all certifying staff. The presentation was done in an informal presentation of information and discussion.
Handouts on infant feeding cues were also distributed. We discussed which of these could be used in appointments and how they could be incorporated into effective counseling.

Our objective was to train staff on the basics of interpreting infant feeding cues and other behavior cues in order to better support participants with feeding, caring for, understanding and bonding with their infants. This information is especially important in supporting breastfeeding dyads.

In-service Three: *Fresh Choices In-service to our Lane County Public Health Nurses, June 1, 2009*

One of our RDs presented information to the Public Health Nurses regarding the upcoming changes to medical documentation requirements, the changes to food packages and the new food lists. Topics discussed also included how the changes conform to the Dietary Guidelines, and the new categories for postpartum women and their infants and how that affects their food packages.

Our objective was to inform one of our closest community partners on what changes to expect, when to expect them and why the changes were being made. The public health nurses share many of our clients and we often work hand in hand with them on these shared clients. They work with them on a variety of health issues including feeding and nutrition issues. They also sometimes do field certifications for WIC when clients are unable to come in to the WIC clinic.

In-service Four: *Participant Centered Counseling, February 4th, 2010.*

A questionnaire "Feedback on Participant Centered Counseling" was distributed to our certifying staff at our December 2009 meeting. The questionnaire asked specific questions on the counseling being used, how it was working, what caused difficulties and examples of phrases/techniques/ approaches that are effective. From the feedback an in-service was created and given February 4th 2010 that addressed the issues and questions that were identified. We did an overview of participant centered counseling, discussed effective techniques and phrases and generated alternatives to "5 Forbidden Phrases" from the December WIC Newsletter. A list of effective phrases and techniques for including open-ended questions, affirmation, asking permission, summarizing and time-saving techniques was compiled and distributed.

Our objective was to identify our staff's current understanding, skills and difficulties regarding Participant Centered Counseling and to further those skills for increasing our effectiveness while working with clients.

Goal 2: Nutrition Education offered by the local agency will be appropriate to the clients' needs.

Year 3 Objective: During plan period, each agency will develop a plan for incorporating participant centered services in their daily clinic activities.

Activity1: Each agency will identify the core components of participant centered services that are being consistently utilized by staff and which components need further developing by October 31, 2009.

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

- Which core components of participant centered services are used most consistently with your staff? What has made those the most easily to adopt?
- Which core components have the least buy-in? What are the factors that make these components difficult to adopt?

Response:
A questionnaire "Feedback on Participant Centered Counseling" was distributed to our certifying staff at our December 2009 meeting. The questionnaire asked specific questions on the counseling being used, how it was working, what caused difficulties and examples of phrases/techniques/ approaches that are effective.

We really did not identify any specific component of Participant Centered Counseling that was not being used. The difficulty with using it seems to be in particular circumstances i.e. time is very short, a child is out of control in a certifiers office and it is very difficult to talk at all, or clients who just do not want to talk no matter how questions are phrased or asked. Time constraints are probably the main barrier to effective client-centered counseling. Many of our staff are very used to doing more traditional, directive, lecturing type of counseling and find this method much more time consuming. Many staff often fall back into what they are used to when stressed. What is needed is continued practice and skill development.

Activity 2: Each agency will implement at least two strategies to promote growth of staff's ability to continue to provide participant centered services by December 31, 2009.

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

- What strategy has been implemented to maintain the core components of participant centered services during a time of change?
- What strategy has been implemented to advance staff skills with participant centered services?

Response:

During the above described in-service on Participant Centered Counseling, a list of effective phrases and techniques for including open-ended questions, affirmation, asking permission, summarizing and time-saving techniques was compiled and distributed. We also addressed methods on ways to use this type of counseling when under time pressure. We discussed using circle charts as a way of identifying which issues the client most wants to discuss and limiting counseling to the most pressing issues.

New staff was trained on "Oregon WIC Listens" by Vernita Reyna, State WIC RD, on August 11, 2009. This was done in a group session.

One-on-one training of certifiers continues. We observe trainees and discuss effective ways to use open ended question, reflections, and affirmations and how to open discussions and summarize.

Sample scripts were written for office assistants and certifiers to help them answer difficult questions on phones, at the front desk, and in appointments. For example a sample script was written to be used when breastfeeding mothers call in asking for formula before their baby is 1 month old.

Goal 3: Improve the health outcomes of WIC clients and WIC staff in the local agency service delivery area.

Year 3 Objective: During planning period, each agency will develop a plan to consistently promote the Key Nutrition Messages related to Fresh Choices thereby supporting the foundation for health and nutrition of all WIC families.

Activity 1: Each agency will implement strategies for promoting the positive changes with Fresh Choices with community partners by October 31, 2009.

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

- Which community partners did your agency select?

- Which strategies did you use to promote the positive changes with Fresh Choices?
- What went well and what would you do differently?

Response:
One of our RDs presented information to the Public Health Nurses regarding the upcoming changes to medical documentation requirements, the changes to food packages and the new food lists. Topics discussed also included how the changes conform to the Dietary Guidelines, and the new categories for postpartum women and their infants and how that affects their food packages.

An e-mail with several attachments was sent to health care providers in Lane County who work with our clients on June 10, 2009. The attachments included an overview of the "Fresh choices" changes ("A Message to Our Partners"), an overview of WIC medical documentation requirements, a copy of the new MDF and foods provided for different categories of clients.

We also met with Headstart on December 9th, 2009, OSU Extension on January 25th 2009, Food for Lane County Food Net meeting on March 10th 2010 and the Lane County Public Health, Health Advisory Committee on October 13th 2009. In each of these meetings an overview of the WIC food package changes was given and there was discussion on how these changes have affected our WIC nutrition education messages.

Activity 2: Each agency will collaborate with the state WIC Research Analysts for Fresh Choices evaluation by April 30, 2010.

Evaluation criteria: Please address the following questions in your response.
- How did your agency collaborate with the state WIC Research Analysts in evaluating Fresh Choices?
- How were you able to utilize, if appropriate, information collected from your agency?

Response:

A bulletin board was displayed in January and Februaryto ask clients to give feedback on the changes in WIC foods and policies brought about by "Fresh Choices".
We provided cards for feed back to the USDA. Comments could either be mailed by us or the client or made on-line (web-site provided).

Goal 4: Improve breastfeeding outcomes of clients and staff in the local agency service delivery area.

Year 3 Objective: During plan period, each agency will develop a plan to promote breastfeeding exclusivity and duration thereby supporting the foundation for health and nutrition of all WIC families.

Activity 1: Using state provided resources, each agency will assess their breastfeeding promotion and support activities to identify strengths and weaknesses and identify possible strategies for improving their support for breastfeeding exclusivity and duration by December 31, 2009.

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:
Assessment of breastfeeding promotion and support activities for Lane County:

Weaknesses identified:
1. Over half our certifying staff and many of our office staff was new since June, 2009. They were totally untrained and had little or no knowledge regarding breastfeeding.
2. Scheduling breastfeeding intervention appointments for women having problems with breastfeeding was a little confusing since appointments were made individually during office time. These office times were set aside for these types of appointments but they were not on the daily schedule. It was

difficult to see where someone could be put in the schedule without finding individual staff people and asking if someone could get seen.
3. Many staff had problems knowing how to talk to breastfeeding clients wanting formula in the first month before formula can be issued to breastfeeding babies.

<u>Strengths identified</u>:

We have:
-Three types of breastfeeding classes: BF Chat, Preparation for Breastfeeding, and a group pump assessment class
-Breast feeding phone support and intervention for all moms requesting formula, seeking help or having questions
-Individual appts and small group sessions for breast pump assessment and instruction
-Individual appointments for breastfeeding problems with trained certifiers, IBCLC, and RDs

We work closely with the lactation consultants from Sacred Heart Hospital. They issue WIC pumps to WIC clients needing them while they are still in the hospital and provide the education on how to use the pumps.

Research shows that one factor in increasing duration of breastfeeding is determined by sharing information about the benefits to mother as well as baby. This information is shared with our clients in our "Preparation for Breastfeeding Class" as well as during prenatal appointments.

"Modesty" aprons were made and given out to breastfeeding clients and women who intend to breastfeed.

Letters to employers on breastfeeding law are supplied to interested clients to give to employers.

The Breastfeeding coordinator and Pump Coordinator(also an IBCLC) meet regularly to assess needs for continued effective promotion and training.

Posters and banners promoting breastfeeding are in all certifier's rooms and the front lobby.

No formula is visible to clients unless it is brought out for individuals in appointments.

All "old" staff has advanced breastfeeding training

Our agency plans to participate in our local breastfeeding coalition meetings.

We have a yearly "Breastfeeding Tea" which is a recognition tea for breast feeding mothers.

Our clinic supported two staff members who breast fed their babies with a private, comfortable place to pump, flexible schedules that accommodated both pumping and going to feed baby by breast during the day. These staff members also had access to and used the advice, problem solving skills and knowledge of our experienced staff members.

Strategies identified to improve support for breastfeeding exclusivity and duration:

-Extensive training of new and inexperienced new staff

-Use of shared information in staff's Outlook calendars on e-mail for helping to find appointment openings for breastfeeding support and intervention. Office staff and certifiers can look into other staff's calendars on Outlook to see when breastfeeding support time-slots are available. Other notes regarding what is needed for the appointment can also be viewed.

-Educating staff on how to talk to clients wanting formula esp. in the first month

Activity 2: Each agency will implement at least one identified strategy from Goal 4, Activity 1 in their agency by April 30, 2010.

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

- Which strategy or strategies did your agency implement to improve breastfeeding exclusivity and duration?
- Based on what you saw, what might be a next step to further the progress?

Response:

Implementation of Strategies

-A sample script was written for office assistants to use when breastfeeding clients request formula before their baby is 1 month of age.
-We now have shared E-mail Outlook calendars to help with making appointments for breastfeeding help for clients
-We have had extensive training of new staff including completion of the Breastfeeding Module, State WIC staff training of our new certifiers, and one-on-one training, and observation of trained staff.

Next steps

-We plan to send two more staff to an advanced breastfeeding training.
-We will have continued meetings of our Breastfeeding Coordinator and our Pump Coordinator (IBCLC) to continue assessment of our need for training and improvement in breastfeeding support in our clinic.
-A new class will be developed i.e. a baby play group for breast feeding mothers and babies. During the class babies could be weighed, infant feeding and breastfeeding could be discussed and questions could be addressed in an informal and supportive atmosphere.
-We will be having breastfeeding friendly spaces in our new building. Our new space has been designed to have two infant feeding rooms adjacent to the lobby that are breastfeeding friendly.

FY 2010 - 2011 WIC Nutrition Education Plan Form

County/Agency: Lane County
Person Completing Form: Leslie Houghton, MS,RD
Date: 4/9/2010
Phone Number: 541-682-4658
Email Address: leslie.houghton@co.lane.or.us

Return this form electronically (attached to email) to: sara.e.sloan@state.or.us
By May 1, 2010
Sara Sloan, 971-673-0043

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 Participant Centered Education e-Learning Modules by July 31, 2010.

Implementation Plan and Timeline:

RDs, and 2 certifiers (Tammy Johnson and Leticia Ibarra) will complete the Participant Centered Education e-learning Module by July 31, 2010.

Activity 2: WIC Certifiers who participated in Oregon WIC Listens training 2007-2009 will pass the posttest of the Participant Centered Education e-Learning Modules by December 31, 2010.

Implementation Plan and Timeline:

All certifying staff will pass the posttest of the Participant Centered Education e-learning Modules by August, 2010. We intend that all certifying staff will be attending the Group Participant Centered Education training in the fall of 2010.

Activity 3: Local agency staff will attend a regional Group Participant Centered Education training in the fall of 2010.

Note: The training will be especially valuable for WIC staff who lead group nutrition education activities and staff in-service presentations. Each local agency will send at least one staff person to one regional training. Staff attending this training must pass the posttest of the Participant Centered Education e-Learning Modules by August 31, 2010.

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

All certifying staff will attend the fall 2010 meeting as all certifying staff teaches classes.

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.

Activity 1: Each agency will continue to implement strategies identified on the checklist entitled "Supporting Breastfeeding through Oregon WIC Listens" by March 31, 2011.

Note: This checklist was sent as a part of the FY 2009-2010 WIC NE Plan and is attached.

Implementation Plan and Timeline:

-Send two" new" certifier staff to advanced breastfeeding training the next time it is offered.

-A new class will be developed i.e. a baby play group for breast feeding mothers and babies. During the class babies could be weighed, infant feeding and breastfeeding could be discussed and questions could be addressed in an informal and supportive atmosphere. Class will be developed by March 31, 2011.

-In the month after the regional Group Participant Centered Education training we will revamp the breastfeeding preparation and prenatal nutrition classes to incorporate state information on evidence-based concepts.

-We will be developing new handouts on breastfeeding topics e.g. low milk supply, galactologues, and mastitis, engorgement, and fussy baby. At least one handout will be developed by January 31, 2011.

Activity 2: Local agency breastfeeding education will include evidence-based concepts from the state developed Prenatal and Breastfeeding Class by March 31, 2011.

Note: The Prenatal and Breastfeeding Class is currently in development by state staff. This class and supporting resources will be shared at the regional Group Participant Centered Education training in the fall of 2010.

Implementation Plan and Timeline:

In the month after the regional Group Participant Centered Education training we will revamp the breastfeeding preparation and prenatal nutrition classes to incorporate State information on evidence-based concepts.

Goal 3: **Strengthen partnerships with organization 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 enhance partnerships with these organization by offering opportunities to strengthen their 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.

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

Implementation Plan and Timeline:

We will invite OSU extension NEP (Nutrition Education Program) staff to attend a regional Group Participant Centered Education training in fall of 2010. NEP staff teach a number of our classes each month.

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 Oregon WIC Breastfeeding Module.

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

Implementation Plan and Timeline:

We will invite community partners that provide breastfeeding education to WIC participants to attend a Breastfeeding Basics training and/or complete the online Oregon WIC Breastfeeding Module. We will reassess who will be invited as we get more information on these trainings. We will likely invite the Public Health Nurses and staff from Healthy Start. Other people who may be interested are from Well Mama (Pregnancy and Postpartum Support Services), LaLeche League and possibly local pediatricians and other medical staff.

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 March 31, 2011.

Implementation Plan and Timeline:

All certifying staff will complete the new online Child Nutrition Module by March 31, 2011.

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

Agency Training Supervisor(s):
Leslie Houghton, RD
Jackie Lucas, RD

See Appendix A for list of planned in-services

Attachment A

FY 2010-2011 WIC Nutrition Education Plan

WIC Staff Training Plan – 7/1/2010 through 6/30/2011

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, 2010 – June 30, 2011. State provided in-services, trainings and meetings can be included as appropriate.

Quarter	Month	In-Service Topic	In-Service Objective
1	*August 2010*	*Group Completion of PCE on-line Module*	*All certifiers will complete the PCE e-learning Modules as a group at an in-service*
2	*October 2010*	*In-service on Developmental Screening for certifiers*	*RDs will be reviewing normal and delayed development, what to look for, and what questions to ask for appropriate referrals and follow-up*
3	*November 2010 January2011 March 2011*	*Certifier-centered education covering issues that arise throughout the year*	*We will address several issues in 3 mini in-services. These in-services will be designed to enhance group and individual counseling performance. They may include presentations from Women's space on domestic violence (awareness,*

			referral and counseling); DHS, housing groups, and/or reviews of specific risks i.e. correct assignment and counseling.
4	*December 2010*	*Group Participant Education*	*Consolidating the information learned at the regional Group Participant Centered Education training and discussing ways to make our classes more participant centered.* *To reinforce information learned at the regional meeting, a discussion and review of evidence-based breastfeeding information is planned for staff meeting.*