



Benton County Health Department

530 NW 27th Street • P.O. Box 579

Corvallis, OR 97339-0579

www.co.benton.or.us/health

Healthy People in a Healthy Community

Health Management Services

Accounting
Business Services
Client Support Services
Contracts
Purchasing
(541) 766-6835
FAX (541) 766-6142

Environmental Health

Drinking Water
Food Safety
Septic Systems
Solid Waste
(541) 766-6841
FAX (541) 766-6248

Mental Health

Administration
Adult Mental Health Service
Chemical Dependency Program
Child Mental Health/ACIST
(541) 766-6835
FAX (541) 766-6175

Developmental Disabilities
(541) 766-6847
FAX (541) 766-6186

New Beginnings
(541) 766-3540
FAX (541) 766-3543

Public Health

Health Promotion
Immunizations
Maternal & Child Health
(541) 766-6835
FAX (541) 766-6142

Communicable Disease
(541) 766-6654
FAX (CD Only) (541) 766-6197

Women, Infants, and Children (WIC)
(541) 766-6835

Benton Community Health Center

Benton Health Center
530 NW 27th Street
P.O. Box 579
Corvallis, OR 97339-0579
(541) 766-6835
FAX (541) 766-6175

Lincoln Health Center
121 SE Viewmont Avenue
Corvallis, OR 97333
(541) 766-3546
FAX (541) 754-4926

Monroe Health Center
610 Dragon Drive
Monroe, OR 97456
(541) 847-5143
FAX (541) 847-5144

April 28, 2008

Mr. Tom Engle
Office of Community Liaison
Oregon Department of Human Services
800 NE Oregon Street, Suite 930
Portland, OR 97232

Dear Mr. Engle:

Enclosed is Benton County's 2008-09 Annual Health Plan, including narrative, fiscal, and minimum standards sections. As requested, this document is being submitted in electronic format. Should you need a signed hard copy, please let me know.

I hope you find these materials satisfactory. Please contact me if you require any further information in support of the Benton County Annual Plan.

Sincerely,

Tom Eversole

Tom Eversole
Benton County Health Administrator

I. EXECUTIVE SUMMARY

Along with many other western Oregon counties, Benton has been facing fiscal challenges in the 2007-2009 biennium. (Unlike most other Oregon counties, Benton is on a biennial budget calendar.) Anticipated problems were somewhat mitigated by the successful passage of a 5-year county levy in November 2007.

Benton County Health Department (BCHD) remains committed to maintaining outstanding and innovative programs. The department is progressing rapidly toward integrating public health, mental health, environmental health and primary care. This work involves re-defining management roles, creating multi-disciplinary work teams, improving health data management, and meeting local health challenges, particularly those facing low income, minority, migrant and high-risk populations. Partnerships and linkages between the Health Department and Benton Community Health Center (FQHC) under the collective rubric of Benton County Health Services are growing and providing a strong continuum of services to County residents.

Many programs increasingly rely upon grant writing, assistance from operation partners, and County General Funds to maintain necessary staffing and service levels unsupported by State funding. Communicable Disease nursing capacity is still sustained in part by using Public Health Preparedness funds in a multiple-hazard approach. The expanding mandates and shrinking funding for PH Preparedness continue to pose a challenge. Community collaborations and creative funding of services for children and families remain strong.

Population-based primary prevention is at the core of tobacco prevention and other Health Promotion programs. Secondary prevention directed toward targeted high-risk groups (pregnant teens, injection drug users, etc) are at the core of other interventions. Activities directed toward chronic disease prevention and management are growing. These involve a broad spectrum of community partners from the Healthy Weight and Lifestyles community coalition, to Samaritan Health Services, OSU extension, a variety of Community-Based Organizations, and others. School Public Health Nurses, under supervision of a BCHD PHN manager, now work in 3 of the 5 school districts educating Benton County children. Drug and alcohol prevention continues to maintain strong collaborations with mental health and be very active in the community with a strong presence in schools.

Awareness of the oncoming “demographic bulge” of aging residents is driving strategic planning and program development. Benton County remains dedicated to providing outstanding preventive and protective public health services to residents and visitors as both the population and health financing change.

II. ASSESSMENT

No updates for 2008-2009.

No updates for 2007-2008.

III. ACTION PLAN

A. EPIDEMIOLOGY AND CONTROL OF PREVENTABLE DISEASES AND DISORDERS

Current Condition or Problem

UPDATE 2008-2009: BCHD CD Nurses and EH Specialists continue to collaborate on prevention and investigation of food-borne infectious diseases. We have initiated a new collaboration with Linn County Health Dept and Linn-Benton Community College to provide infection control & disease prevention modules to their program which is the regional source of continuing education for licensed day-care providers.

Benton County continues to be a relatively transient community and experiences a relatively high turnover of healthcare providers in the medical community. As new providers join practices, there is a need to orient them to the disease reporting requirements specific to the Benton County Health Department and Oregon. Encouragement to providers to raise their awareness of the need to call regarding suspect or atypical cases is inherently hindered by the managed care policy of not documenting “suspect” but only known diagnoses. This is a conflict in the system for early reporting to the Health Department.

Labs tend to report more consistently and promptly than providers in Benton County. Chlamydia is the most commonly reported disease in Benton County. It has been our experience that the CD staff receives reports on Chlamydia before the provider. We often notify the provider as a result of our call for more demographic and clinical information. Sometimes the clinical staff requests a release of medical information from the client prior to their responding with that information. With private providers hearing from us frequently, this is not a problem.

Benton County Health Department’s CD program is looking forward to a level of staffing and stability we have not had in some time. As of April 30th, we will have two FTE of dedicated CD RN staff. This should enable us to implement a schedule of educational outreach to area clinicians addressing their lack of understanding regarding CD surveillance and reporting.

The CD staff was significantly challenged during the summer of 2003 by two imported cases of measles within the OSU community. This was successfully dealt with partly as a direct result of significant SARS planning we had done with OSU. At the time of this writing, we are in the midst of a pertussis outbreak – life remains exciting in the Benton County CD program.

Update 2007-08: CD nurses and EH specialists worked closely with long-term-care (LTC) facilities and preschool/daycare centers to assess outbreaks and provide education for limiting the spread of norovirus. We used active surveillance to identify epi-linked cases of Shigella in a neighborhood outbreak and found presumptive cases.

Update 2006-07: Fortunately the pertussis outbreak abated, and levels of this disease returned to baseline levels. The CD nurses were able to return to work that had been deferred for the duration of the outbreak.

Update 2005-06: BCHD's CD program was challenged to the maximum in 2004 by a year-long pertussis outbreak which resulted in over 250 confirmed and presumptive cases which averaged 8-9 contacts per case. CD nurses tracked the use of over 1,800 doses of antibiotic prophylaxis and spent over 1,500 hours of salaried time on this investigation. Virtually all surge capacity staff were involved in this investigation at one time or another. All of the provider communication and health alerts raised BCHD's profile in the community, but many local providers questioned such widespread use of antibiotics.

Goal

UPDATE 2008-2009: The BCHD CD program remains strongly partnered with the OSU Infectious Disease Response Team and OSU Health and Safety office. These linkages have proven invaluable in facilitating prevention activities on campus as well as in investigation and media management of outbreaks involving the OSU community.

Work with BCHD Health Promotion team to plan and implement outreach CD surveillance and reporting education program for area health providers.

Maintain and expand outbreak and bioterrorism planning with community partners.

Activities

CD staff continues to get requests and/or offers educational presentations to private providers and clinical staff. Whether the requested topic is latent TB, SARS, or Hepatitis C, reporting requirements and protocol for confidentiality and the Health Department role in surveillance and investigation is included. Although the CD staff has made presentations to some private clinics, a well-planned surveillance and reporting promotion program is not yet in place. The CD nurses will work with the BCHD Health Promotion team to implement evidence-based health promotion best practices in this outreach effort.

Local CD "Health Alerts," "Health Advisories," and "Health Updates" are also sent to all medical and alternative healthcare providers via fax and email. This serves the dual purposes of informing providers of current, prevalent symptoms seen in the community or State and reminding them of their requirement to report to the Health Department. The Health Officer reviews all releases prior to distribution.

The CD staff maintains active relationships with local infection control practitioners and nurse managers of clinics and urgent care including OSU Student Health Services. School nurses, employees of the Health Department, do active surveillance for the populations they serve in collaboration with the CD nurse. There is also collaboration with CD nurses of neighboring counties.

Following an investigation of an outbreak, the provider and involved facility (e.g. long-term care, school, or day care) receive feedback on the outcome of the investigation. This reinforces the role of surveillance and investigation by the Health Department to the provider or facility who initiated the report.

Increasing the CD program's visibility in the County and maintaining a consistent level of responsiveness to reports and inquiries by providers will be ongoing.

Update 2007-08: Community education efforts focused on pandemic flu preparedness to audiences of pastors and parish nurses, business organizations, medical clinic staff, EMS and school staff. CD nurses are a resource to private providers in TB case management. We introduce them to the new CDC TB treatment protocol using 4-drug therapy for 8 weeks when there is high suspicion of TB until sputum cultures are done and a repeat comparison chest x-ray is obtained.

Update 2006-07: Two major areas of activity have been outreach to shelters, group homes, residential treatment centers, etc. to improve their TB prevention plans. CD staff also participated in an outreach effort to improve hepatitis A/B immunization rates among IDUs and other high-risk populations. They were also able to fully participate in the November 2005 MDC exercise and updating of the OSU infectious disease response plan.

Update 2005-06: The pertussis outbreak resulted in significant provider contact and communication. DHS provided significant assistance for a pertussis CME presentation to area pediatricians. All other provider outreach activities were put on hold.

Evaluation

UPDATE 2008-2009: No update

The OCHIN practice management system is providing a significant amount of nurse productivity data. Additionally, the BCHD epidemiologist is working on development of a case report log. This will provide a mechanism to track reports and provide better feedback and reinforcement to area health providers.

Update 2007-2008: Information from the Data Base issued for regular Quality Assurance and Quality Improvement reviews. Nurse utilization and true costs of investigations and outreach activities will be tracked as well.

Update 2006-07: The full implementation of the Multnomah County CD database has provided a mechanism for internal QA/QI monitoring. This is now a quarterly standing agenda item within the CD team. This process has allowed the team to better track cases and thereby provide more timely and consistent feedback to providers.

Update 2005-06: BCHD's CD program has grown quite robust. Two full-time CD nurses bring significant skills and stability. The program was challenged in 2004 by an unprecedented local pertussis outbreak in addition to the "normal" range of investigations. The pertussis outbreak allowed an opportunity for significant outreach education and increased both the visibility and awareness of public health among providers and the public. Schools were the locus of all clusters and cooperation was good.

In addition to maintaining participation in DHS CD trainings, BCHD also hosted a meeting of over 24 counties to discuss proposed modifications to the pertussis investigative guidelines.

Tuberculosis

Current Condition or Problem

UPDATE 2008-2009: No update

Currently we are following a large number of LTBI cases, all of which are taking INH. Most of these cases are identified through the School Clearance TB Screening or by a private provider who does medical screening for immigration. Due to the fact that the local university has a large international student population, OSU Student Health Services currently handles a caseload of about ten LTBI on INH. Both the Health Department and the SHS staff are aware of the cultural conflicts for treating LTBI. There are a significant number of foreign-born people identified with LTBI who choose not to start therapy.

The CD staff and SHS providers discussed the conflicts of foreign-born clients with LTBI experience due to their cultural and/or religious beliefs when advised to start therapy. Although there is written material available in various Asian, African, and Spanish languages about LTBI and INH, there is a lack of culturally proficient health education strategies available to respond more effectively.

Goals

Greater understanding and more effective TB outreach, particularly to the Asian-Pacific community.

Activities

Benton County serves both Korean and Chinese clients more commonly than other Asian populations. A university intern worked last summer to conduct outreach information gathering within the Asian-Pacific community, to obtain information on common beliefs about LTBI and begin development of culturally proficient messages to encourage LTBI treatment.

The final product will be singular, clear health promotion statements and counseling topics for use by CD clinicians. These messages will be meaningful and culturally proficient for the Korean client. It will be shared with the OSUSHS clinicians and any other interested clinics (e.g., Immigration Medical Screening Clinic).

Update 2007-2008: BCHD CD nurses have recently received significant in-service TB training from DHS TB program staff. Ongoing outreach training to local service partners continues.

Update 2006-07: No increase in TB has been noted. Outreach to improve staff and resident screening at high-risk shelters has been undertaken and well received.

Update 2005-06: BCHD continued to monitor a few LTBI cases periodically. We also had 2 active TB cases in the past year. Although TB cases are labor-intensive, all cases were handled routinely.

One remarkable cluster occurred when an active case was identified in Polk County with contacts in Benton. The case was under cancer therapy at the Corvallis hospital, so a large number of staff and fellow patients needed to be assessed. Many of the patients posed difficult issues since their cancer therapy had weakened their immune responses.

**B. PARENT AND CHILD HEALTH SERVICES INCLUDING
FAMILY PLANNING CLINICS AS DESCRIBED IN
ORS 435.205**

IMMUNIZATION PROGRAM

See Appendix B.

B. CONTINUED

FY 2007 - 2008 WIC NUTRITION EDUCATION PLAN FORM

County/Agency: Benton County Health Department

Person Completing Form: Marjean Austin and parts by Leslie Redpath

Date: April 10, 2007 (Original date), April 11, 2008 (Completed 2007-08 Nutrition Education Plan submitted this date)

Phone Number: 541-766-6836

Email Address: marjean.austin@co.benton.or.us (Retired 2-29-2008)

Current WIC Lead: Leslie Redpath

Phone Number: 541-766-6173

Email Address: leslie.r.redpath@co.benton.or.us

Return this form electronically (attached to email) to: sara.e.goodrich@state.or.us

by May 1, 2007

Sara Sloan Goodrich, 971-673-0043

Goal 1:

Oregon WIC Staff will have the knowledge to provide quality nutrition education.

Year 1 Objective:

During plan period, staff will be able to correctly assess nutrition and dietary risks.

Activity 1

All certifiers will complete the Nutrition Risk Module by December 31, 2007.

Resources: Nutrition Risk Module distributed to all agencies 2/07. Information provided from Nutrition Risk Module Regional Train-the-Trainer sessions 4/07.

Implementation Plan and Timeline:

Nutrition educators (certifiers) will complete the Nutrition Risk Module by December, 31, 2007.

Updated 2008- All of the nutrition educators (certifiers) completed the Nutrition Risk module by Dec. 2007. They have incorporated this information into their present certifications.

Activity 2

All certifiers will complete the revised Dietary Risk Module (to be released September 2007) by March 31, 2008.

Resources: Information provided from Dietary Risk Module Training.

Implementation Plan and Timeline:

Nutrition educators (certifiers) will complete the revised Dietary Risk Module by March 31, 2008.

Updated 2008 - All of the nutrition educator (certifiers) completed the revised Dietary Risk module by Nov. 2007. They are utilizing the information in their daily practice.

Activity 3

Each agency will select at least one staff member to participate in a State workgroup to identify key nutrition messages used in WIC and implement strategies for integrating these messages into clinic practices. See Attachment A for details on participation and content.

Staff name(s): Leslie Redpath

Email address(s): leslie.r.redpath@benton.or.us

Phone Number(s): 541-766-6173

Updated 2008 - Leslie Redpath participated in the workgroup to identify key nutrition messages. She gathered information from the staff and submitted a page of key nutrition messages.

Activity 4

Identify your agency training supervisor(s) and projected staff in-service training dates and topics for FY 2007-2008. Complete and return Attachment B by May 1, 2007.

WIC Calendar 2007

January RISK IDENTIFICATION- State WIC staff. FI AUDIT TIMESTUDY	February	March ANNUAL WIC EMPLOYEE SIGNATURE FORM/CONFIDENTIALITY
April FI AUDIT TIMESTUDY	May STAFF TRAINING-Motivational Interviewing (5/19/07) PREP FOR FARM DIRECT	June CHART AUDIT FARM DIRECT ISSUANCE

<p align="center">July</p> <p align="center">FI AUDIT</p> <p align="center">TIMESTUDY</p>	<p align="center">August</p> <p align="center">SCALE CALIBRATION</p> <p align="center">WORLD BF/HEALTH FAIRE ACTIVITIES</p>	<p align="center">September</p> <p align="center">STAFF TRAINING-Civil Rights</p> <p align="center">FRUIT AND VEGGIE MONTH</p>
<p align="center">October</p> <p align="center">FI AUDIT</p> <p align="center">TIMESTUDY</p>	<p align="center">November</p> <p align="center">STAFF TRAINING-Cultural Sensitivity</p>	<p align="center">December</p> <p align="center">CHART AUDIT</p> <p align="center">ANNUAL LAB HEMOCUE COMPETENCY</p>

Monthly: Run these reports and follow-up with appointment, call, postcard or letter:

1st Week of Month:

- Clients with No FI's
- No Show Cert/Recert
- End Cert/Terms
- Pending Proofs/Rx needed
- FLPP Check Stock Inventory
- Breast Pump Inventory
- Voter Registration

2-3rd Week of Month:

- High Risk
- Terminations
- Autoscheduler
- Autoscheduler unable to schedule

RD No Shows rescheduled after 1st Friday and 4th Monday RD Clinics

WIC Calendar 2008

<p align="center">January</p> <p>Staff training-Alcohol abuse symptoms and referral process- Marie Laper, Mental Health Program Manager</p> <p align="center">FI AUDIT</p> <p align="center">TIMESTUDY</p>	<p align="center">February</p> <p align="center">Staff training-Gestational diabetes-by Inge Daeschel, RD</p>	<p align="center">March</p> <p align="center">ANNUAL WIC EMPLOYEE SIGNATURE FORM/CONFIDENTIALITY</p>
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<p style="text-align: center;">April</p> <p style="text-align: center;">FI AUDIT</p> <p>Cultural Diversity Training (County sponsored)</p> <p style="text-align: center;">TIMESTUDY</p>	<p style="text-align: center;">May</p> <p style="text-align: center;">WIC State meeting-</p> <p style="text-align: center;">STAFF-Civil Rights training</p>	<p style="text-align: center;">June</p> <p style="text-align: center;">FARM DIRECT ISSUANCE</p>
<p style="text-align: center;">July</p> <p style="text-align: center;">FI AUDIT</p> <p style="text-align: center;">TIMESTUDY</p>	<p style="text-align: center;">August</p> <p style="text-align: center;">SCALE CALIBRATION</p> <p style="text-align: center;">WORLD BF/HEALTH FAIRE ACTIVITIES</p>	<p style="text-align: center;">September</p> <p style="text-align: center;">FRUIT AND VEGGIE MONTH</p>
<p style="text-align: center;">October</p> <p style="text-align: center;">FI AUDIT</p> <p style="text-align: center;">TIMESTUDY</p>	<p style="text-align: center;">November</p>	<p style="text-align: center;">December</p> <p style="text-align: center;">Chart Audit</p> <p style="text-align: center;">ANNUAL LAB HEMOCUE COMPETENCY</p>

Monthly: Run these reports and follow-up with appointment, call, postcard or letter:

1st Week of Month:

- Clients with No FI's
- No Show Cert/Recert
- End Cert/Terms
- Pending Proofs/Rx needed
- FLPP Check Stock Inventory
- Breast Pump Inventory
- Voter Registration

2-3rd Week of Month:

- High Risk
- Terminations
- Autoscheduler
- Autoscheduler unable to schedule

RD No Shows rescheduled after 1st Friday and 4th Monday RD Clinics

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

Year 1 Objective A:

During Plan period, each local agency will implement strategies to provide targeted quality nutrition education.

Activity 1

Using state-provided resources, conduct a needs assessment of your community by September 30, 2007, to determine relevant nutritional health concerns and assure that your nutrition education offerings meet the needs of your WIC population.

Resources include: TWIST Reports, PEDS Data, Oral Health Data, Healthy Active Oregon Communities' Initiatives. Resources will be provided July 2007.

Implementation Plan and Timeline:

Complete a needs assessment of WIC clients in Benton County to determine relevant nutritional health concerns by August 31, 2007.

Compare these health concerns to the nutrition education topics offered to WIC clients and determine if the topics cover the identified needs from the Needs Assessment. Modify nutrition education topics if necessary to fulfill the identified needs from the Needs Assessment by September 30, 2007.

Update 2008 - Analysis utilizing Nutrition Risk Prevalence Table revealed that the most common risk factors in Benton County WIC clients in all categories were: overweight, high weight gain, and inadequate consumption of fruits and vegetables. This data was consistent across all WIC sites in Benton County and also shown in the Adult Survey for Fruits and Vegetables which showed that only 26% of Benton County residents ate 5 or more servings of fruit and vegetables weekly. The modifiable risk factors found among adults in Benton County between 2002-05 showed that approximately 36% were overweight with another 15% classified as obese and 58% of the residents met CDC recommendations for physical activity.

Activity 2

Complete Activity 2A or 2B depending upon the type of second nutrition education activities your agency offers.

Resources include: Information from Goal 2, Activity 1, Oregon WIC Nutrition Education Guidance.

Activity 2A

By October 31, 2007, submit an Annual Group Nutrition Education schedule for your agency for 2008. Complete and return Attachment C by October 31, 2007. Make copies of the schedule as needed. If your agency does not offer group nutrition education activities, complete Activity 2B.

Implementation Plan and Timeline:

Not applicable to Benton County

Activity 2B

If your agency does not offer group nutrition education activities, how do you determine 2nd individual nutrition education is appropriate to the individual client's needs?

Response:

Based on the client’s identified nutrition risk, at mid-cert follow up appointment the client picks one of their nutrition risks for their goal. The staff then educates them about their risks and engages clients to determine measures they could take to work towards obtaining their nutrition goal by the next WIC appointment.

Update 2008 - Clients were receptive to above approach. The majority of clients were able to meet their goal by their next appointment.

Goal 3:

Improve the health outcomes of clients and staff in the local agency service delivery area.

Year 1 Objective:

During Plan period, each local agency will develop at least one specific objective and implement at least one activity to help facilitate healthy behavior change for WIC staff and at least one specific objective and activity to help facilitate healthy behavior change for WIC clients.

This objective gives you the opportunity to address relevant issues and “customize” activities for your agency. For example, you could utilize findings from the prior 3-Year Nutrition Education Plan to determine the most common barriers to making healthy behavior changes. Develop the objective and activity to address those barriers.

Activity 1

Local Agency Objective to facilitate healthy behavior change for WIC Staff: To increase physical activity by incorporating it into staff workday.

Local Agency Staff Activity: Walking during break and/or lunch period.

Implementation Plan and Timeline:

Include why this objective was chosen, what you hope to change, how and when you will implement the activity, and how you will evaluate its effectiveness.

Incorporate physical activity into their work day by walking either during a break or at lunch hour. This objective was chosen since staffs have busy lives before and after work. Block the time slot before lunch so they can complete their work prior to lunch so they have enough time to be active. Begin this objective by July 1, 2007.

Survey staff quarterly by just asking this simple question:

During the past month, how many times did you walk during break or lunch hour?

_____ 1-2x weekly

_____ 3-4x weekly

_____ daily

Analyze the data from the above question and see if there is an improvement in the number of times the staff walked at work during the week.

Response:

Each of the WIC staff are active physically - one exercises and runs 1.5 hours before riding her bike daily to work; another teaches 6-9 exercise classes/week before and after work; and the last staff member often walks during breaks/lunch and exercises in the evening with her 5-year-old son. She has told me that they either bike or walk to the park most evenings. I have also observed staff walking around the park during their breaks...this activity has seemed to have increased over the last year.

The original survey did not capture the high level of daily exercise the entire staff does, so the narrative above should satisfy frequency. These physical activities have been ongoing for all staff for many years.

Activity 2

Local Agency Objective to facilitate healthy behavior change for WIC Clients: Clients will increase their physical activity by walking.

Local Agency Client Activity: Health education, tips, and resources will be shared with clients to promote this objective.

Implementation Plan and Timeline:

Include why this objective was chosen, what you hope to change, how and when you will implement the activity, and how you will evaluate its effectiveness.

Increase physical exercise by walking for longer periods of time or accumulated amount of time (summation of daily activities). This objective was chosen since it can fit in anyone's budget and timeframe.

At each certification/re-certification visit, provide client with a copy of "Physical Activity Pyramid". Review the activities with the client and ask the client which activities they would be interested in doing. Encourage the client to do one of these activities daily.

Evaluation: During the last month of each quarter (September 2007, December 2007, and March 2008) at the Individual Education Follow-up Appointment. Randomly selected clients will complete the mini-survey below. Analyze the data by May 2008.

Response:

Bold indicates percentages of all mini-surveys combined from September 2007-March 2008. (n=68)

- 1. During the past month, how many times did you walk during break or lunch hour?**

<u>46%</u>	1-2x weekly
<u>34%</u>	3-4x weekly
<u>21%</u>	daily

2. If you were unable to increase your exercise, what of the below activities got in our way.
- 29% a) not enough time
 - 28% b) children
 - 9% c) household tasks
 - 8% d) other *(Motivation, holidays, work, weather, not interested, tired, lazy, school)*

The survey indicates that 55% of respondents walk 3-7 times/week. Certifiers discuss exercise with all clients as well as offer local resources to assist them in increasing their families and their own exercise levels. Resources include Park & Recreation catalog, informing of low-income fee waivers/discounts available, offering Benton County Healthy Active Resource Guide, “Get More Energy”, Child Physical Activity Pyramids, and “99 Tips for Family Fitness”.

Barriers to increasing exercise were grouped around ‘not enough time’ and ‘children’. Staff is conscientious about reminding participants of the importance of involving children in their own exercise activities. Staff offers suggestions on keeping activity simple and regular, such as walk briskly instead of slow, park farther from destination and walk, and use stairs when possible and safe.

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

Year 1 Objective:

During Plan period, each local agency will develop at least one objective and activity to help improve breastfeeding outcomes for WIC staff or WIC clients.

Consider using findings from the prior 3-Year Nutrition Education Plan to help identify and address common barriers to breastfeeding.

Activity 1

Breastfeeding Objective: To increase the rate of breastfeeding rates even if it is partial breastfeeding.

Breastfeeding Activity supporting the above objective:

- At the time of visit for New Pregnant Women, distribute and discuss information on the handout entitled, “101 Reasons to Breastfeed.”
- Benton County WIC program has developed this motto: “Some is better than none”. We will develop education and incentives around this motto.

Implementation Plan and Timeline:

Include why this objective was chosen, what you hope to change, how and when you will implement the activity, and how you will evaluate its effectiveness.

Increase the rate of breastfeeding by saying that some breastfeeding is better than none makes this a more attainable goal for some clients. By promoting partial breastfeeding, we might have a secondary gain of increasing breastfeeding-only rates.

Evaluation: Our marketing of partial breastfeeding will begin in August 2007 with World Breastfeeding Week. By June 30th, 2008, compare the rates of partial packages with those number of packages distributed in June 30th, 2007. Also compare the rates of fully breastfeeding for the same dates to see if there was a secondary gain.

Response (Leslie Redpath):

Evaluation timeline is amended and reflected in the table and narrative below. There will not be a June 2008 comparison and the following will conclude the evaluation of the 2007-08 NE breastfeeding components.

Below is a table of breastfeeding percentages for 2007-08, from TWIST Participant Reports, showing one month's rates (June 2007) before implementing the Breastfeeding Plan, the month the Plan was implemented (August 2007), and 2 months (January and March 2008) following implementation for results.

	WE	WB	WN	n= #PP Women	WE + WB (n=T
June 2007 (before BF Plan)	58%	21%	29%	226	80%
August 2007 (during BF Plan)	59%	20%	22%	218	78%
January 2008 (5 mo. after Plan)	46%	25%	29%	208	71%
March 2008 (7 mo. after Plan)	47%	27%	26%	199	74%

The table indicates that the percentages of exclusively breastfeeding women decreased from June 2007 to March 2008 while there was a 6% increase (21% to 27%) in women partially breastfeeding. The total overall women (WE + WB) who breastfed during the comparison months decreased from 80% to 74%.

It is difficult to attribute any of the above listed increases and decreases in exclusive and partial breastfeeding percentages in Benton County. There are many variables outside the control of our staff or participants.

Breastfeeding is discussed at every certification and follow-up appointment for all pregnant women. All pregnant women are also offered a private breastfeeding consultation. Breastfeeding consults may have poorer show rates due to increased offerings of classes through the local clinics/hospital in conjunction with the prenatal classes.

AMENDED INFORMATION:

Benton County WIC Program just received results from the CDC's 2007 Pediatric Nutrition Surveillance Survey (PedNSS), Table 7F, indicating that Benton County WIC has the highest percentage of moms who are:

- **Breastfeeding at least 6 months (62.2%, #1 ranked in Oregon)**
- **Breastfeeding at least 12 months (43.2%, #1 ranked in Oregon)**
- **Exclusively breastfeeding at least 3 months (64.2%, #1 ranked in Oregon)**
- **Exclusively breastfeeding at least 6 months (55.3%. #1 ranked in Oregon)**

This data was from January 1 through December 31, 2007, and is unlikely influenced by the FY 2007-08 Nutrition Education Plan breastfeeding activities listed in the breastfeeding objectives. There is no way to connect the activities and program successes although they may have contributed some.

It is more likely that the highly experienced and motivated staff with strong client-centered ethics and belief in the importance of breastfeeding is a major contributing factor.

B. CONTINUED

FY 2007-2008 EVALUATION OF WIC NUTRITION EDUCATION PLAN

WIC Agency: Benton County WIC Program
Person Completing Form: Leslie Redpath
Date: April 11, 2008 Phone: _____

Return this form, attached to email to: sara.e.sloan@state.or.us by May 1, 2008

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

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

Year 1 Objective: During plan period, staff will be able to correctly assess nutrition and dietary risks.

Activity

All certifiers will complete the Nutrition Risk Module by December 31, 2007.

Outcome evaluation: Please address the following questions in your response.

- Did all certifiers successfully complete all the activities of the Nutrition Risk Module by December 31, 2007? **Yes**
- Were the completion dates entered into TWIST and the competency achievement checklist filed for each certifier? **Yes, see Response**

Response:

All certifiers successfully completed all activities of Nutrition Risk Module and completion dates were entered into TWIST:

Certifier	Nutrition Risk Module date	Dietary Risk Module Date	Entered into TWIST? Y/N	Competency Achievement Checklist Filed? Y/N
Maryam Jones	4-12-07	11-28-07	Y	See Note
Mercedes Magana	7-26-07	11-28-07	Y	See Note
Leslie Redpath	7-26-07	11-28-07	Y	See Note

Note: Competency Achievement Checklists were not filed since Leslie Redpath took over Lead position March 1, 2008. Benton County WIC is a small, close, highly

experienced and professional team of 3 who have worked together over 12 years. In place of the Competency Achievement Checklists for the Nutrition Risk Module and Dietary Risk Module, we have found that meeting weekly and discussing strengths & weaknesses and areas needing modification or improvement are a more useful learning tool for staff. We also meet spontaneously, as needed, to discuss our implementation of the Nutrition Risk Module and Dietary Risk Module questions. I am confident in saying that the staff is implementing the 2 new modules as intended based on the trainings.

Activity 2

All certifiers will complete the revised Dietary Risk Module by March 31, 2008.

Outcome evaluation: Please address the following questions in your response.

- Did all certifiers successfully complete all the activities of the Dietary Risk Module by March 31, 2008? **Yes**
- Were the completion dates entered into TWIST and the competency achievement checklist filed for each certifier? **Yes, see Response**

Response:

All certifiers successfully completed all activities of Dietary Risk Module and completion dates were entered into TWIST:

Certifier	Nutrition Risk Module date	Dietary Risk Module Date	Entered into TWIST? Y/N	Competency Achievement Checklist Filed? Y/N
Maryam Jones	4-12-07	11-28-07	Y	See note
Mercedes Magana	7-26-07	11-28-07	Y	See note
Leslie Redpath	7-26-07	11-28-07	Y	See note

Note: Competency Achievement Checklists were not filed since Leslie Redpath took over Lead position March 1, 2008. Benton County WIC is a small, close, highly experienced and professional team of 3 who have worked together over 12 years. In place of the Competency Achievement Checklists for the Nutrition Risk Module and Dietary Risk Module, we have found that meeting weekly and discussing strengths & weaknesses and areas needing modification or improvement are a more useful learning tool for staff. We also meet spontaneously, as needed, to discuss our implementation of the Nutrition Risk Module and Dietary Risk Module questions. I am confident in saying that the staff is implementing the 2 new modules as intended based on the trainings.

Activity 4

Identify your agency training supervisor(s) and staff in-service dates and topics for FY 2007-2008.

Outcome evaluation: Please address the following questions in your response.

- Did your agency conduct the staff in-services you identified? **Yes**
- Were the objectives for each in-service met? **Yes**
- How do your staff in-services address the core areas of the CPA Competency Model?
See Response

Response:

Staff exceeded the in-services identified. In addition to the trainings listed below, WIC staff attends Bloodborne Pathogen, Cultural Sensitivity Trainings, and complete an annual Lab Competency Review sponsored by the Benton County Health Department. Each March all Health Department staff working with WIC review and sign the State WIC Confidentiality form.

Staff in-services whose objectives were met for FY 2007-08					
Certifier	Civil Rights Training	Oregon Fruit & Veggie Summit (OSU)	Alcohol use by pregnant women (Marie Laper, Mental Health)	Gestational Diabetes (Inge Daeschel, RD)	Cultural Diversity, Getting to know LGBT Community (County sponsored at library)/Benton County Cultural Diversity Training
Maryam Jones	9-12-07	10-8-07	11-21-07	2-6-08	4-16-08
Mercedes Magana	9-12-07	10-8-07	11-21-07	2-6-08	2-14-08/4-16-08
Leslie Redpath	9-12-07	10-8-07	11-21-07	2-6-08	2-14-08/4-16-08
Marjean Austin	9-12-07		11-21-07	2-6-08	

The in-services improved the needs identified by staff regarding increasing awareness of tools to use to improve participant use of fruits and vegetables, improving staff understanding of gestational diabetes and how staff can best reinforce RD recommendations, and increasing our sensitivity and understanding of the needs and issues faced by the lesbian, gay, bisexual and transgender community. Staff identified a need to better understand techniques to address pregnant women who may be using alcohol and initiated and in-service by the Drug & Alcohol Program Manager in Mental Health. The Civil Rights Training is required and done annually to reinforce its importance.

Staff also meets weekly to review cases and issues that arise. This format acts as an in-service and seminar and is staff-directed.

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

Year 1 Objective: During plan period, each agency will implement strategies to provide targeted, quality nutrition education.

Activity1

Using state-provided resources, conduct a needs assessment of your community by September 30, 2007 to determine relevant health concerns and assure that your nutrition education activity offerings meet the needs of your WIC population.

Outcome evaluation: Please address the following questions in your response:

- Was the needs assessment of your community conducted? **Tables and reports (listed below) were used to perform the community assessment in conjunction with information from the Benton County Health Educator and her assessment tools.**
- What health concerns did you determine were relevant to your community? **Health concerns were identified as: Overweight, high weight gain, inadequate consumption of fruits and vegetables, and inadequate physical activity.**
- What did you do with the information you collected? **We use the information to reinforce our messages to clients concerning the importance of healthy weight, diet and physical activity.**
- Who did you communicate the results of your needs assessment with? **Staff meets to discuss results and identify and/or reinforce our key messages to clients.**

Response (By Marjean Austin in FY 2007-08 Nutrition Education Plan):

“Update 2008 - Analysis utilizing Nutrition Risk Prevalence Table revealed that the most common risk factors in Benton County WIC clients in all categories were: overweight, high weight gain, and inadequate consumption of fruits and vegetables. This data was consistent across all WIC sites in Benton County and also shown in the Adult Survey for Fruits and Vegetables which showed that only 26% of Benton County residents ate 5 or more servings of fruit and vegetables weekly. The modifiable risk factors found among adults in Benton County between 2002-05 showed that approximately 36% were overweight with another 15% classified as obese and 58% of the residents met CDC recommendations for physical activity.”

Activity 2

Complete Activity 2A or 2B depending upon the type of second nutrition education activities your agency offers.

Activity 2A

By October 31, submit an Annual Group Nutrition Education schedule for 2008.

Activity 2B

If your agency does not offer group nutrition education activities, how do you determine 2nd individual nutrition education is appropriate to the clients' needs?

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

- If your agency offers group nutrition education, did you submit your Annual Group Nutrition Schedule for 2008?
- How do you assure that your nutrition education activities meet the needs of your WIC population?

Response:

Benton County WIC provides individual and small group Breastfeeding Consultations (1 month prior to EDD) for all pregnant women. These are 30 minute, one-to-one appointments where we provide a comprehensive packet of information, review breastfeeding basics, and show a short video. We also provide Farm Direct orientations in both individual and group settings July – September.

Benton County WIC does not offer other group nutrition education. Instead, all clients are offered a follow-up appointment in 1-3 months with certifiers unless the client is in need of a RD appointment, which will be scheduled in an appropriate time frame.

Clients have appreciated and attended individual follow-ups better than group offerings of the past. The individual appointment is 15 minutes; measurements and hemoglobin (if needed) are checked; and previous goals are reviewed, evaluated, reset (if needed), and documented as needed.

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

Year 1 Objective: During plan period, each local agency will develop at least one specific objective and activity to help facilitate healthy behavior change for WIC staff and at least one specific objective and activity to help facilitate healthy behavior change for WIC clients.

Activity 1

Local Agency Objective to facilitate healthy behavior change for WIC staff. Local Agency Staff Activity.

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

- How did your agency decide on this objective and activity? **Manager decided on this objective and activity with some input from staff.**
- Did the activity help meet your objective? **No. Staff already exceeded activity levels. (See Response)**
- What went well and what would you do differently? **(See Response)**

Response: (per Marjean Austin with some edits by Leslie Redpath)

Each of the WIC staff are active physically - one works out, lifts weights, and runs before riding her bike daily to work; another teaches 6-9 exercise classes each week before coming to work; and the last staff member exercises in the evening with her 5-year-old son. She has told me that they either bike or walk to the park most evenings. I have also observed staff walking during their lunch hours and around the park during their lunches and breaks. This activity has increased over the last year. The staff is atypically healthy, active, and self-motivated.

Activity 2

Local Agency Objective to facilitate healthy behavior change for WIC clients. Local agency Client Activity.

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

- How did your agency decide on this objective and activity? **Coordinator made the decision with some staff input.**
- Did the activity help meet your objective? **No, questions did not target population very clearly and did not provide an accurate method to identify change or improvement.**
- What went well and what would you do differently? **Better questions that better address participant's real life situations, including stay at home moms, working moms, and students.**

Response: Results of survey:

Bold indicates percentages of all mini-surveys combined from September 2007-March 2008. (n=68)

3. During the past month, how many times did you walk during break or lunch hour?
- | | |
|------------|-------------|
| <u>46%</u> | 1-2x weekly |
| <u>34%</u> | 3-4x weekly |
| <u>21%</u> | daily |
4. If you were unable to increase your exercise, what of the below activities got in our way.
- | | |
|------------|--|
| <u>29%</u> | a) not enough time |
| <u>28%</u> | b) children |
| <u>9%</u> | c) household tasks |
| <u>8%</u> | d) other <i>(Motivation, holidays, work, weather, not interested, tired, lazy, school)</i> |

The survey indicates that 55% of respondents walk 3-7 times/week. Certifiers discuss exercise with all clients as well as offer local resources to assist them in increasing their families and their own exercise levels. Resources include Park & Recreation catalog, informing of low-income fee waivers/discounts available, offering Benton County Healthy Active Resource Guide, "Get More Energy", Child Physical Activity Pyramids, and "99 Tips for Family Fitness".

Barriers to increasing exercise were grouped around 'not enough time' and 'children'. Staff is conscientious about reminding participants of the importance of involving children in their own exercise activities. Staff offers suggestions on keeping activity simple and regular, such as walk briskly instead of slow, park farther from destination and walk, and use stairs when possible and safe.

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

Year 1 Objective: During plan period, each local agency will develop at least one objective and activity to help improve breastfeeding outcomes for WIC staff or WIC clients.

Activity 1

Local Agency Breastfeeding Objective. Local Agency Breastfeeding Activity.

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

- How did your agency decide on this objective and activity? **Coordinator and staff discussed the objective and activity in a meeting.**
- Did the activity help meet your objective? **The activity was not designed to accurately compare a baseline to identify change and did not account for variables outside the influence of certifiers. (See Response)**
- What went well and what would you do differently? **(See Response)**

Response:

Activity 1

“Breastfeeding Objective: To increase the rate of breastfeeding rates even if it is partial breastfeeding.

Breastfeeding Activity supporting the above objective:

- **At the time of visit for New Pregnant Women, distribute and discuss information on the handout entitled, “101 Reasons to Breastfeed.”**
- **Benton County WIC program has developed this motto: “Some is better than none”. We will develop education and incentives around this motto.”**

Increase the rate of breastfeeding by saying that some breastfeeding is better than none makes this a more attainable goal for some clients. By promoting partial breastfeeding, we might have a secondary gain of increasing breastfeeding only rates.

Evaluation: Our marketing of partial breastfeeding will begin in August 2007 with World Breastfeeding Week. By June 30th, 2008, compare the rates of partial packages with those number of packages distributed in June 30th, 2007. Also compare the rates of fully breastfeeding for the same dates to see if there was a secondary gain.”

Response (Leslie Redpath):

Evaluation timeline is amended and reflected in the table and narrative below. There will not be a June 2008 comparison and the following will conclude the evaluation of the 2007-08 NE breastfeeding components.

Below is a table of breastfeeding percentages for 2007-08 showing one month’s rates (June 2007) before implementing the Breastfeeding Plan, the month the Plan was implemented (August 2007), and 2 months (January and March 2008) following implementation for results.

	WE	WB	WN	n= #PP Women	WE + WB (n=T of WE + WB only)
June 2007 (before BF Plan)	58%	21%	29%	226	80%
August 2007 (during BF Plan)	59%	20%	22%	218	78%
January 2008 (5 mo. after Plan)	46%	25%	29%	208	71%
March 2008 (7 mo. after Plan)	47%	27%	26%	199	74%

The table indicates that the percentages of exclusively breastfeeding women decreased from June 2007 to March 2008 while there was a 6% increase (21% to 27%) in women partially breastfeeding. The total of overall women (WE + WB) who breastfed during the comparison months decreased from 80% to 74%.

It is difficult to attribute any of the above listed increases and decreases in exclusive and partial breastfeeding percentages in Benton County. There are many variables outside the control of our staff or participants.

Breastfeeding is discussed and promoted at every certification and follow-up appointment for all pregnant women. All pregnant women are also offered a private breastfeeding consultation. It is my observation that more seem to be refusing the WIC consultation and taking advantage of the class now offered through the local clinics/hospital in conjunction with the prenatal classes.

AMENDED INFORMATION:

Benton County WIC Program just received results from the CDC's 2007 Pediatric Nutrition Surveillance Survey (PedNSS), Table 7F, indicating that Benton County WIC has the highest percentage of moms who are:

- Breastfeeding at least 6 months (62.2%, #1 ranked in Oregon)
- Breastfeeding at least 12 months (43.2%, #1 ranked in Oregon)
- Exclusively breastfeeding at least 3 months (64.2%, #1 ranked in Oregon)
- Exclusively breastfeeding at least 6 months (55.3%. #1 ranked in Oregon)

This data was from January 1 through December 31, 2007, and is unlikely influenced by the FY 2007-08 Nutrition Education Plan breastfeeding activities listed in the breastfeeding objectives. There is no way to connect the activities and program successes although they may have contributed some.

It is more likely that the highly experienced and motivated staff with strong client-centered ethics and belief in the importance of breastfeeding is a major contributing factor.

Submitted by:

Leslie Redpath, MPH
 Benton County WIC Lead
 541-766-6173

Leslie.r.redpath@co.benton.or.us

April 11, 2008

B CONTINUED

FY 2008 - 2009 WIC Nutrition Education Plan Form

County/Agency: Benton County WIC

Person Completing Form: Leslie Redpath

Date: 4-15-2008

Phone Number: 541-766-6173

Email Address: leslie.r.redpath@co.benton.or.us

Return this form electronically (attached to email) to: sara.e.sloan@state.or.us
by May 1, 2008
Sara Sloan, 971-673-0043

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

Year 2 Objective: During plan period, through informal discussions, staff in-services and/or targeted trainings, staff will be able to describe the general content of the new WIC food packages and begin to connect how these changes may influence current nutrition education messages.

Activity 1

By October 31, 2008, staff will review the Oregon WIC Key Nutrition Messages and identify which one's they need additional training on.

Resources: American Academy of Pediatrics, MyPyramid.gov, Maternal and Child Health Oral health website – <http://www.mchoralhealth.org/Openwide/> Information from the 2008 WIC Statewide meeting.

Implementation Plan and Timeline:

- 1. WIC staff in-service by August 31, will involve staff reviewing**
 - a. The new WIC food packages**
 - b. WIC Key Nutrition Messages**
 - c. Discuss which messages connect best with sections of the new food packages**
- 2. Staff will identify any WIC Key Nutrition Messages that need additional training**
- 3. Additional training identified by staff will be provided by September 30, 2008**

Activity 2

By March 31, 2009, staff will review the proposed food packages changes and:

- Select at least three food packages modifications (for example, addition of new foods, reduction of current foods, elimination of current foods for a specific category);

- Review current nutrition education messages most closely connected to those modifications; and
- Determine which messages will remain the same and which messages may need to be modified to clarify WIC's reasoning for the change and/or reduce client resistance to the change.

Resources: WIC Works Website WIC food package materials, Information from the 2008 WIC Statewide meeting, State provided materials.

Implementation Plan and Timeline:

By March 31, 2009, during WIC staff in-service, WIC staff will:

- 1. Identify 3 or more new food package modifications that they feel will cause the most questions/problems for clients.**
- 2. Identify which WIC Key Nutrition Messages are most useful in communicating those food package changes**
- 3. Modify any Key Nutrition Messages they identify as needing a different message to better communicate the change and improve client compliance.**
- 4. Incorporate identified Key Nutrition Messages and modified messages in all future certification and follow-up appointments.**

Activity 3

Identify your agency training supervisor(s) and projected staff in-service training dates and topics for FY 2008-2009. Complete and return Attachment A by May 1, 2008.

See Attachment A

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

Year 2 Objective: During Plan period, each agency will assess staff knowledge and skill level to identify areas of training needed to provide participant centered services.

Activity 1

By September 30, 2008, staff will review the diet assessment steps from the Dietary Risk Module and identify which ones they need additional training on.

Implementation Plan and Timeline:

By September 30, 2008, at staff seminar, WIC staff will:

- 1. Review diet assessment steps from the Dietary Risk Module,**
- 2. Identify areas needing additional training,**
- 3. Provide identified training at that seminar, and/or**
- 4. Schedule additional training for next WIC meeting.**

Activity 2

By November 30, 2008, staff will evaluate how they have modified their approach to individual counseling after completing the Nutrition Risk and Dietary Risk Modules.

Resources include: State provided guidance and assessment tools.

Implementation Plan and Timeline:

By November 30, 2008, at staff seminar, WIC staff will:

- 1. Review and share personal counseling modifications they have made since completing the Nutrition Risk and Dietary Risk Modules**
- 2. Identify and clarify any areas of confusion in the sections, chapters, Information Sheets and Job Aids of both Modules**
- 3. Evaluate effectiveness of those changes and how they are received by clients**

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

Year 2 Objective: During plan period, in order to help facilitate healthy behavior change for WIC staff and WIC clients, each local agency will select at least one objective and implement at least one strategy from the Statewide Physical Activity and Nutrition Plan 2007-2012.

Activity 1

Identify your setting, objective and strategy to facilitate healthy behavior change for WIC staff.

Setting: Worksite

Objective I: By 2012, increase by 10 percent the number of worksites with policies and programs that promote and support physical activity and healthy eating for employees and their family members.

Strategy b: To develop policies and programs, employers should use a worksite wellness toolkit, the state's Breastfeeding Mother Friendly Employer toolkit, or similar publications that provide examples of the benefits of physical activity and healthy eating.

Resource: Attachment B - A Healthy Active Oregon: Statewide Physical Activity and Nutrition Plan 2007-2012, Recommended Objectives and Strategies

Implementation Plan and Timeline: Include why this objective was chosen, what you hope to change, how and when you will implement the strategy, and how you will evaluate its effectiveness.

Implementation Plan and Timeline: This objective was chosen to motivate staff to increase their own walking physical activity levels, motivate WIC participants to walk more through staff interest and enthusiasm, and for weekly free pedometer give-away drawings during July and August 2008 (See Activity 2). The intention is to motivate staff to compete with themselves to increase their daily walking. Baseline daily step averages will be established in April 2008 and compared to July-August daily step averages. Baselines have already been established by April 30, 2008, in anticipation of this activity.

Implementation: Walking will be defined as steps taken by staff from individual 5 (or more)-day averages. Baseline steps/day measurements will be obtained by April 30, 2008, and then compared to individual 5 (or more)-day average steps/day between July 1 and August 31, 2008, as measured by individual pedometer readings. Results from both April and August pedometer steps will be recorded as an average daily step for both baseline and final readings.

Staff will also (See Activity 2) initiate discussion about walking and the pedometer activity they are participating in and offer prenatal and postpartum women clients seen in July and August the opportunity to be entered in a weekly drawing to win a pedometer. A grand prize drawing of an incentive (such as family pass to aquatic center) will be held in September.

Evaluation: Staff baseline and final daily step averages after August 31, will be compared to identify increased average daily steps from baseline. Staff will also discuss and evaluate by September 30, 2008, the effectiveness, successes, problems, and motivators in their changes in daily step averages between April and summer measurements.

Activity 2

Identify your setting, objective and strategy to facilitate healthy behavior change for WIC clients.

Setting: Home/Household

Objective I: By 2012, increase by five percent the number of Oregon adults and children who meet the recommendation for physical activity.

Strategy f: Educational and health organizations should provide families with information and resources promoting physical activity.

Resource: Attachment B - A Healthy Active Oregon: Statewide Physical Activity and Nutrition Plan 2007-2012, Recommended Objectives and Strategies.

Implementation Plan and Timeline: Include why this objective was chosen, what you hope to change, how and when you will implement the strategy, and how you will evaluate its effectiveness.

Implementation Plan and Timeline: This objective was chosen to motivate pregnant and postpartum WIC participants to increase their walking physical activity levels through both staff enthusiasm for staff's pedometer physical activity program and weekly free pedometer give-aways during July and August 2008. We hope to change client attitudes to increasing their walking activity levels with a pedometer to help them see how active they actually are and what it takes for them individually to increase their own number of steps taken daily.

Implementation: WIC staff will be mentioning their pedometer program to women participants during July and August 2008. They will offer interested WIC Program participants the opportunity to enter a weekly drawing to win a free new pedometer, chart, and information/motivation sheet. There will also be a grand prize drawing by September 5, 2008, for all who entered the weekly drawings to win a grand prize, such as free family day pass to the Aquatic Center.

Evaluation: Participant interest will be evaluated by the number of women who were interested enough to enter the drawing as compared to the number of women (prenatal and postpartum) seen during the months of July and August, 2008.

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

Year 1 Objective: During Plan period, in order to help improve breastfeeding outcomes for WIC participants, each local agency will select at least one setting objective and implement at least one strategy from the Statewide Physical Activity and Nutrition Plan 2007-2012.

Resource: Attachment B - A Healthy Active Oregon: Statewide Physical Activity and Nutrition Plan 2007-2012, Recommended Objectives and Strategies.

Activity 1

Setting: Home/Household

Objective I: By 2012, maintain the current level of breastfeeding initiation and increase by two percent a year the number of mothers who breastfeed exclusively for the first six months of a child's life.

Strategy d: Health plans, health systems, hospitals and others shall promote breastfeeding campaigns targeting the entire family.

Implementation Plan and Timeline: Include why this objective was chosen, what you hope to change, how and when you will implement the strategy, and how you will evaluate its effectiveness.

Implementation Plan and Timeline: This objective was chosen because the most recent data from the Pediatric Nutrition Surveillance Survey (PedNSS) from the CDC indicated that the Benton County WIC Program has the highest percentage of moms who are exclusively breastfeeding at 6 months (55.3%), and moms who are still breastfeeding at six months (62.2%), in the state of Oregon. We feel that continuing what we are doing will continue to maintain and increase the percentages of exclusively breastfeeding, and still breastfeeding at six months, mom's in Benton County.

Implementation: WIC staff will continue implementing their current strategy for promoting and increasing exclusive breastfeeding and mom's breastfeeding at least 6 months by:

1. Using participant-centered discussions to help inform all clients about the advantages of breastfeeding for all pregnant women and postpartum women who are breastfeeding at all, at every WIC certification and follow-up and individual breastfeeding consultation appointment.
2. Using participant-centered discussions to help inform all clients about the WIC Breast pump program for those going back to work or school.
3. Discussing that some breastfeeding is better than none for pregnant participants who are not planning to breastfeed or undecided if they want to breastfeed.
4. Offering the '101 Reasons to Breastfeed' sheet to all pregnant women.
5. Schedule all postpartum women into an appointment to be recertified, and to certify their newborn infants, as quickly as possible. This is typically scheduled within 10 days of notification of infant's birth. These appointment slots are not scheduled with the Autoscheduler, only manually. There are typically 6 appointment slots/day held open and available for scheduling quickly.

6. Providing individual breastfeeding consultations, with information packet and video, to all pregnant women.
7. Offering washable breast pads and Lansinoh Cream to all breastfeeding moms at their initial appointment with the infant.
8. Returning all calls regarding breastfeeding problems within 24-48 hours of call. Always offering encouragement and support for mom to continue to breastfeed.
9. Referring clients with issues beyond the expertise of staff with local referrals, resources, and support groups as needed.

Evaluation: Effectiveness will be evaluated, in part, by reviewing 2008 Pediatric Nutrition Surveillance Survey (PedNSS) from the CDC by May 2009, and identifying percentage changes from PedNSS 2007.

B. CONTINUED

MCH PROGRAM PLANS (Parent and Child Health Services) 2008-09

UPDATE 2008-09: PLAN REMAINS UNCHANGED

UPDATE 2007-08: PLAN REMAINS UNCHANGED.

UPDATE 2006-07: PLAN REMAINS UNCHANGED.

UPDATE 2005-06: PLAN REMAINS UNCHANGED.

Current Condition Or Problem

The MCH program of Benton County consists of Oregon Mother's Care and the Prenatal Program for clients ineligible for OHP, Maternity Case Management (MCM), Babies First (BF), Cacoon, and consultation to the Benton County Healthy Start program. Due to limited funding, BCHD has only 1 FTE to do the home visiting programs (MCM, BF, Cacoon, and Healthy Start). As a result, BCHD has had to prioritize clients for these programs.

In September 2003, a Maternity Care Coordinator was hired by Good Samaritan Hospital. The physicians at this hospital refer their pregnant clients for care coordination services. As a result of this position, many women with either drug and alcohol problems or chronic mental illness have been identified. BCHD is presently seeing these clients for assessment purposes and determining the needs that these women present. We have found that there are gaps in mental health services for some of these women within Benton County public and private mental health providers.

Oregon Mothers Care and Prenatal Program

Since January 2003, The Oregon Mother's Care program has been incorporated into the present Prenatal Program. A bilingual/bicultural Health Aid coordinates the combined OMC/Prenatal Program. Through the Oregon Mother's Care program, the Health Aid helps clients obtain healthcare during their pregnancy and helps them fill out applications for Oregon Health Plan. If they are not eligible for the OHP because they are non-citizens, she will screen them for Benton County Prenatal Program and Citizen Alien Waived Emergency Medical (CAWEM). We anticipate that this program will grow in the present difficult economic times, and we will need more staff time and money to support these services.

The Benton County Prenatal Program serves clients who have an income less than 185% of poverty, are not eligible for OHD, and do not have health insurance.

Maternity Case Management (MCM) is a home visiting program that Benton County has prioritized for pregnant teens and is provided by a Maternal Child Home visiting nurse. Benton County has prioritized services to teens due to the limited funding that supports the MCH nurse

activities. In addition, this year pregnant women with either drug or alcohol problems or chronic mental illness are being assessed and case managed as appropriate. **FOR 2008-09- OPENING CASELOAD FOR ALL HIGH RISK PREGNANT WOMEN.**

The Babies First (BF) and Cocoon program targets high-risk children. This includes the medically fragile children in the Cocoon program. This program also targets parenting teens and is based on the David Olds' model. David Olds is a research- based home visiting program that has shown effective outcome with low-income moms with their first-born child.

Healthy Start is a new program in Benton County since March 2002 and is housed in two different nonprofit agencies. The MCH nurses provide nursing consultation to the paraprofessionals that provide home visiting parent support to new moms in Benton County.

WIC

The Women, Infant, and Children program (WIC) provides nutrition education and food vouchers to low-income pregnant women (see Nutrition Plan – Appendix A in the Appendixes document). ACIST mental health clinicians provide counseling and parenting information to families in their home or clinic settings.

Safety Net Review

The designated Safety Net Provider in Benton County will review the cases that have not risen to the level of DHS/Child Welfare Services. These clients will be visited and an appropriate program will be developed to meet the family's goal.

MDT and Child Fatality Review

The Deputy Administrator of Community Health and the Health Administrator help review and design plans for prevention of child abuse in Benton County. Training for Mandatory Reporters is the responsibility of the MDT.

Goals

Objective 1: Women who are enrolled in Maternal Child Health programs will obtain nutrition education and food vouchers to help improve their nutritional intake and status.

Activities

1. MCH nurses will either refer clients to WIC or enroll them in WIC during their home visitation services.
2. MCH will discuss appropriate and healthy food choices for pregnant women and children according to developmental age.
3. Screening height and weight for age will assess a child's development.
4. Weight gain will be monitored during pregnancy.

Evaluation

1. Ninety-five percent of eligible clients in the Maternal Child Program will also enroll in WIC services.
2. Ninety percent of teen caseload babies will have normal growth and development patterns as measured through the Babies First program.

Both of the above goals were obtained in the MCH program.

Update-2008: Goals were met

Update-2007: Goals were met.

Update-2006 : Goals were met.

Update 2005: Goals were obtained.

Objective 2: Pregnant women will access prenatal care during the first four months of their pregnancy

Activities

1. The OMC program that was just started in early 2003 will continue to be marketed.
2. We will work with DHS Self-sufficiency to refer all pregnant clients to OMC.
3. We will continue to find funding for the OMC program position.

Evaluation

Seventy-nine percent of unmarried women will access prenatal care during their first four months of pregnancy.

Upon completion of the Birth Certificate data information for Benton County, determine whether the above objective was met.

Update 2007-08:

77.9% of prenatal clients received prenatal care in the first trimester during 2007 (OMC data).

88.5% of prenatal clients received prenatal care in the first trimester during 2006 (OMC data).

90.3% of prenatal clients received prenatal care in the first trimester during 2005 (OMC data).

Update 2006: 100% of prenatal clients received care in their first trimester during 2004 (OMC state data).

Update 2005: 73.5% of prenatal clients received care in their first trimester during 2003 (state data).

Objective 3: Breastfeeding will be promoted in Benton County teen mothers

Activities

1. Teens will be given information through WIC regarding nutritional benefits of breastfeeding their child.
2. The MCH Nurse will provide breastfeeding support during home visits.
3. The lactation specialist for clients who are experiencing breastfeeding difficulties will be utilized.

Evaluation

Seventy-five percent of the MCH caseload initiated breastfeeding.

Update 2008: Goal was met. 92 % of WIC clients initiated Breastfeeding.

Update 2007: Goal was met.

Update 2006: Goal was met.

Update 2005: Goal was met

Dental Services

Dental services are inadequate to serve the County population. Oregon Oral Health Profile shows that only 67% of the Oregon population visited the dentist in the past year vs. 67.9% in the US. Forty-two dentists work in Benton County. No dentists offer a sliding fee scale and few take Medicaid. Low income and uninsured people have difficulty accessing the private dentists because their caseloads are already filled with insured and private pay clients. An estimated 7,000 low income County people in the service area are in need of urgent and ongoing dental care. The loss of Oregon Health Plan Medicaid standard package dental coverage in March 2003 will increase the need for dental providers who will serve the target population.

UPDATE 2008-2009: Oral health and Fluoride varnish program transitioned to Community Health Center (FQHC) Jan. 2008. Oral health coalition is still going strong. Presently, working on dental clinic for high risk children to be located in the Boys & Girls Club and to be dental services provided by volunteer local dentists.

UPDATE 2007-2008: Curative dental services continue to be provided on a contract basis through a local dentist. In addition, preventive oral health is being done via dental varnishing by PHNs integrated into primary care and WIC services. With the addition of a primary care pediatrician on the clinical medical staff, it is hoped that this prevention program can be significantly expanded in the coming year.

Update 2006-07: Due largely to extreme capital and start-up costs, dental services will continue to be provided via a contract with a local dentist. This arrangement has worked well so far and client satisfaction is high.

Update 2005-06: The dental component of the FQHC provided services through a contract with a local dental provider in 2004. In late 2005 or early 2006, BCHD anticipates employing a dentist, dental assistant, and hygienist and building or purchasing a dental clinic.

Update 2004-05: In December 2003, BCHD resubmitted an application for funding as a Federally Qualified Health Center. A decision of award is expected before the end of April 2004. BCHD is the lead applicant and will, if successful, manage the grant and the clinical services. If successful, physical, mental, and dental patient care is expected to commence by September.

C. ENVIRONMENTAL HEALTH

This section is optional and is left intentionally blank.

D. HEALTH STATISTICS

Current Condition or Problem

BCHD currently has a fairly strong capacity to collect, track, and analyze health statistics. In addition to programmatic staff and managers, BCHD is fortunate to employ a 0.5 FTE epidemiologist and enjoys a close working relationship with many members of the OSU faculty in Public Health, Social Work, Nutrition, and many other fields.

The current data analysis capability will be improved with the activation of a fully integrated medical information system.

Update 2008-2009: Epidemiologist position remains unfunded and vacant. Partial refunding is anticipated in FY 08-09.

Update 2007-2008: Budget constraints have resulted in the loss of the epidemiologist position. The database is now overseen by the CD nurses.

Update 2006-07: The BCHD epidemiologist oversees a fully functional CD database now. Capacity within this system will be enhanced within the year with a wireless system and tablet PCs for the CD nurses allowing them to increase their mobility while still being connected to the system.

Update 2005-06: The BCHD staff epidemiologist has been on staff for over a year. The Multnomah County CD database is now fully active. CD nurses are currently transitioning from a paper-base reporting system to a fully electronic reporting system.

Update 2004-05: The BCHD staff epidemiologist position has been refilled after a temporary vacancy. The OCHIN MIS system is now fully active. Activation of the Multnomah County CD database is in process.

Goals

The BCHD epidemiologist and medical records staff maintain both mandatory and voluntary tracking of vital statistics, demographics, and biostatistics from outside literature. Supplying the epidemiologist with new computer software will improve both retrospective and real-time analysis of data.

Update 2008-2009: Department-wide data integration is ongoing. It is anticipated that this process will be facilitated and accelerated with return of epidemiology capacity.

Update 2007-2008: Public Health data is gradually being integrated as department-wide data systems are upgraded.

Update 2006-07: The CD database is fully implemented. Budget constraints have slowed progress on other public health data tracking. We hope to implement a system early in FY 2006-2007.

Update 2005-06: The CD database has been fully implemented. Implementation of the primary prevention database is planned for this year. The primary prevention database will use Access database software and will be capable of tracking non-medical, non-billable prevention program information that the OCHIN practice management system is incapable of handling.

Update 2004-05: Implementation of the CD database as well as a “home-grown” database system to track primary public health activities is planned for this year. The primary prevention database will use SPSS statistical software and will be capable of tracking non-medical and non-billable client information such as behavior change questionnaires, pre and posttests, outreach program participation, outreach staff utilization, and other quantitative data that the OCHIN practice management system is incapable of handling.

Activities

BCHD is planning to activate a fully integrated medical information system by late fall 2003. This system will allow us to more fully exploit the information we are already collecting and capture much information which is now missed. Additionally, we are planning to provide our epidemiologist with the latest version of the SPSS biostatistics package, which will allow advanced data analysis.

We are making our epidemiologist an official member of the CD program and will install the Multnomah County ACCESS database for CD monitoring. We are planning to use this both for retrospective analysis of past CD effectiveness to provide real-time monitoring of current trends and “red flag” identified CD problems as they occur.

UPDATE 2008-2009: No changes

Update 2007-2008: No changes

Update 2006-07: No changes in this plan.

Update 2005-06: The BCHD Epidemiologist maintains the integrity of the CD database, and is in the process of implementing the primary prevention database. The Epidemiologist also has access to a new software program (VistaPHw), which allows for retrospective analysis of mortality rates, birth rates, and communicable disease status for the entire state of Oregon.

Update 2004-05: Our Epidemiologist will be the focal point for both CD and prevention database information.

Evaluation

The vital statistics portion of the Department will continue to measure benchmarks according to relevant OARs and ORSs. The epidemiologic analyses will often be designed and evaluated in concert with the DHS epidemiologists and evaluation, and quality-control criteria will be built into each study or system.

Update 2008-2009: No changes

Update 2007-2008: No changes

Update 2006-07: No changes in this plan.

2005-2006 Update: None.

2004-05 Update: In addition to internal resources, we will utilize partners at OSU, other LHD's, and DHS to evaluate and modify our prevention database.

E. INFORMATION AND REFERRAL SERVICES

Current Conditions

Information and Referral (I & R) services are up to the discretion of each health department. Oregon Administrative Rule (OAR) 333-014-0050 mandates that local health departments provide information and referral services. Beginning in the 03-04 fiscal year, the Benton County Health Department has been providing Information and Referral services within the Administrative and Business Services (ABS) Division. Information and Referral has maintained established services, including telephone referrals for housing, medical care, social services, and coordination of applications for the Oregon Health Plan. The I & R directory has been converted to an on-line format internally and access licenses have been made available on line to BCHD partner agencies.

Activities

BCHD I & R activities:

- Promote community health and wellness by assisting individuals and families in receiving County services with special attention to maintaining and ensuring confidentiality.
- Interview clients to obtain selected background information and establish eligibility to make use of County resources.
- Help clients identify needs that are related to County services, explain and encourage use of community resources to deal with identified problems, and make referrals to sources of help.
- Provide administrative/clerical support to the Department's Automatic Call Distribution (ACD) by directing internal staff, other governmental agencies, nonprofit organizations, community members, and clients to the appropriate contact or by providing the requested/necessary information.
- Facilitate enrollment and application to the Oregon Health Plan, and refer clients to appropriate organizations for OHP certification/enrollment.

Evaluation

Utilizing the OCHIN electronic practice management system, evaluation of I&R activities include the following:

- Number of calls received
- Number of referrals made and for what services
- Number of OHP applications completed
- Demographic information on clients
- Follow-up information gathered to determine utilization of resources

Update 2008-2009: No changes

Update 2007-2008: No changes

Update 2006-07: Love, Inc. has now published a new I&R reference book for Benton County and Corvallis. The BCHD continues to provide limited direct I&R service through the Community Health Center reception staff.

Update 2004-05: The Information and Referral Guide is now being compiled by a non-profit organization called Love Inc.

F. OTHER ISSUES

HEALTH PROMOTION-DISEASE PREVENTION PROGRAM 2004-2005

Update 2008-2009: Funding for Harm Reduction program activities was secured by an add-back of County general funds. This program benefits from strong support of the Benton County Sheriff, Benton County Public Works and Parks departments, as well as from strong and outspoken support of local HIV/AIDS prevention activists.

Chronic Disease prevention funding is a patchwork of small grants. The addition of the tobacco chronic disease funding will provide much-needed funding for a complete community assessment which we anticipate will, in turn, can help leverage additional funding.

Substance abuse programming remains strong with continuing funding through a SAMHSA grant. The Mental Health Division of BCHD works in close partnership with Public Health to provide funding for primary prevention activities within the BCHD Health Promotion team.

The MARS program has continued to grow with new partnerships in Jackson, Deschutes, Marion and Multnomah counties. The main funding source for MARS – federal office of family planning (OPA) funding ends at the close of Federal FY 2007-2008. Collaborative grant writing is underway to find ways to sustain this innovative and well-received program.

UPDATE 2007-2008: The Harm Reduction / Needle Exchange portion of HIV prevention programming is in jeopardy due to budget reductions. Outcome depends upon county budget decisions due by June 2007. Epidemiologist position has been eliminated due to budget constraints. Chronic Disease prevention has been moved to the MCH program under the supervision of the Public Health Program Manager to better coordinate children's obesity prevention with school health and other MCH programming.

UPDATE 2006-07: NONE

UPDATE 2005-06: NONE

The mission of the Health Promotion/Disease Prevention Program at the Benton County Health Department is to provide public health prevention equitably and professionally to all people in Benton County by engaging the community in planning, policymaking, implementing, and evaluating health prevention and promotion programs. The Health Promotion/Disease Prevention Division of the Benton County Health Department implements prevention programs in Benton County using the Institute of Medicine Model (IOM) prevention framework, which includes Universal, Selected, and Indicated prevention programs.

There are eight program areas within the Health Promotion/Disease Prevention Program. These include:

Substance Abuse Prevention
Tobacco Prevention
HIV Prevention
Sexual Health Promotion
Latino Health Promotion Outreach
Breast and Cervical Cancer Prevention
Chronic Disease Prevention.
Epidemiology

Within each of these programs are several projects. The following narrative will discuss the Health Promotion/Disease Prevention program areas including the current condition or problem, program activities, and evaluation.

Substance Abuse Prevention Program

Current Condition or Problem

According to the Oregon Healthy Teen survey, approximately 25% of 8th graders and 48% of 11th graders have used alcohol in the past 30 days. In addition, 12% of 8th graders and 16% of 11th graders have used marijuana in the past 30 days. In order to address substance abuse in Benton County, the Substance Abuse Prevention Program consists of five project areas.

These include:

Community mobilization
Prevention outreach to middle school youth
Parent education
Underage drinking prevention
Latino outreach

The Substance Abuse Prevention Program is funded through the State AD 70 Dollars. Please see the AD70 Plan for program goals, activities, and evaluation in Appendix C in the Appendixes document.

During 2003-2004 the Benton County Substance Abuse Prevention Program completed the following activities:

- Provided mini-grants and technical assistance to eight community-based organizations to conduct substance abuse prevention interventions.
- Implemented Botvin's Life Skills curriculum in three of Benton County's five school districts to approximately 700 middle school students.
- Provided technical assistance to the Parent's Network to support the network's implementation of parent education in the community.
- Conducted two merchant partnership trainings in collaboration with the OLCC, OSU, and local law enforcement agencies to alcohol and tobacco retailers in Benton County.

- Designed a “We I.D.” campaign for local alcohol retailers.
- Provided parent education in Spanish to approximately 25 families.

For 2004-2005 the Benton County Substance Abuse Prevention Program will conduct the following program activities:

- Provide community mobilization and technical assistance to six community-based organizations.
- Provide prevention education to high school and middle school students by continuing to implement Life Skills and implementing Reconnecting Youth.
- Implement targeted underage drinking programs in Philomath and Corvallis that include a collaborative effort with the OLCC, OSU, local law enforcement agencies, and local merchants.
- Train the Benton County Health Department Promotora Program in substance abuse prevention and how to make substance abuse treatment referrals.
- Continue to provide technical assistance to the Parent’ s Network to support their efforts in the implementation of parent education in the Benton County.

Tobacco Prevention

Current Condition or Problem

Tobacco-related deaths in Benton County in 1999 account for 23% of all deaths. Approximately 22% of males and 19% of females in Benton County smoke. Twenty-eight percent (28%) of these adults are between the ages of 18 to 24 years old. Twenty-one percent of all adults in Benton County smoke. Approximately 12% of 8th graders and 14% of 11th graders have smoked within the past 30 days. The annual estimated economic cost of tobacco related issues in Benton County is \$27.4 million.

Goals

Tobacco prevention is a primary focus of the Benton County Health Department. The goals of the Tobacco Prevention Program are:

- Building community capacity through the Benton County Tobacco Free Coalition
- Reducing youth access through Merchant Partnership Program
- Creating Tobacco-Free Environments
- Reducing Tobacco Advertising and Promotion
- Promoting linkages to cessation

In 2003-2004 the Benton County Health Department was the only health department in Oregon that continued their Tobacco Prevention and Control Program through County Unrestricted Funds when the state Tobacco funds were discontinued. From April 2003 to February 2004, the Benton County Health Department implemented the following activities:

- Continued to provide technical assistance to the Benton County Tobacco-Free Coalition.
- Implemented Tobacco Intervention Classes in the 509J School District.
- Implemented a collaborative project with Good Samaritan Health Services to provide free cessation classes to Benton County residents who want to quit smoking.
- Continued to monitor the local Benton County and city ordinances for enforcement and education.

Activities

The activities to be implemented in 2004-2005 that address the Benton County Tobacco Prevention and Control Program are listed below:

- Technical assistance and administrative support to the Benton County Tobacco Free Coalition.
- Implement a Merchant Partnership Program.
- Education and enforcement regarding the Corvallis, Philomath, and Benton County Smoke Free Ordinances.
- Provide Tobacco Education in the schools.
- Provide technical assistance to the Benton County school districts to implement the basic elements of a smoke-free school.
- Implement Tobacco Intervention classes in the schools.
- Employee education on tobacco cessation.

- Develop tobacco-free ordinances for city and county parks.

Evaluation

The evaluation methods of the tobacco prevention program activities are:

- Number of coalition meetings per year and number of attendances.
- Pre and posttests of tobacco education classes.
- Number of ordinance complaints needing follow up.
- Survey of employee education on tobacco cessation.
- Survey of merchants.
- Number of parks that become designated as tobacco-free.
- Number of school districts that implement the basic elements of tobacco-free schools.

HIV Prevention and Ryan White Care Case Management

Current Condition or Problem

In 2001, approximately 1,716 individuals received HIV Testing and Counseling. Of these there were two positive test results. At present, there are approximately 12 to 13 active Ryan White cases. The components of the HIV Prevention Program for 2004-2005 are:

- Outreach to the gay, bisexual, and transgender community regarding HIV prevention.
- Confidential and anonymous HIV Testing.
- A Harm Reduction Outreach Program targeting active intravenous drug users.
- Ryan White Case Management for people living with HIV/AIDS.
- Youth outreach on HIV prevention strategies.
- Outreach to the Latino community on HIV prevention strategies.
- Community planning through the Benton County HIV Prevention and Care Planning Committee.

Activities

During 2003-2004 the HIV Prevention Program accomplished the following activities:

- Participated as a pilot site for the Oraquick Rapid Testing and provided approximately 50 Oraquick tests to high-risk individuals in nontraditional settings.
- Conducted 160 offsite HIV testing and counseling interventions.
- Held 24 HIV positive support groups with an average attendance of 5 to 6 persons per support group.
- Held 6 HIV Prevention Planning Committee meetings with an average membership of 10 community partners.
- Distributed condoms in 9 bars in Benton County every two weeks.
- Exchanged approximately 20,000 needles to active IDUs.
- Implemented 32 HIV/AIDS and Hep. C classes to 216 participants.
- Implemented Be Proud! Be Responsible! to 430 students in Benton County.

The activities for the HIV Prevention Program during 2004-2005 include the following:

- HIV positive support group.
- Outreach to MSM engaged in high risk behaviors.
- HIV testing and counseling.
- HIV Prevention education to high risk groups.
- Harm Reduction Outreach program.
- Implementation of Safety Counts for active IDUs.
- Methods include: Van, on-call services, street outreach and drop in.
- Technical assistance and administrative support to the HIV Prevention Planning Committee.
- Implementation of Be Proud! Be Responsible! In Benton County schools.
- Outreach to gay, lesbian, and bisexual youth.
- Ryan White Case Management.

Evaluation

The evaluation methods in the HIV Prevention Program include:

- Pre and posttests.
- Completion of Encounter sheets.
- Completion of Ryan White Care Ware.
- Community Needs Assessments.
- Number of Ryan White clients.
- Number of HIV Prevention Planning Committee meetings and number of members who attend.
- Number of needles exchanged.
- Number of HIV positive support groups and number in attendance.

Adolescent Sexual Health

Current Condition or Problem

According to the Oregon Health Teen Survey, approximately 14% of 8th graders and 28% of 11th graders in the Benton County School Districts have had sex. Of these, 28% of the 8th graders DID NOT use condoms, and 47% of the 11th graders DID NOT use condoms. In addition, 35% of 8th graders reported using alcohol and/or drugs when having sex, and 18% of 11th graders reported using alcohol and/or drugs when having sexual intercourse.

The Benton County Health Department Health Promotion/Disease Prevention Program provides a population-based approach to addressing adolescent sexual health. Programs offered to adolescents and young adults include the following: 1) The Male Advocates for Responsible Sexuality (MARS) and 2) The STARS Program (Students Today Aren't Ready for Sex).

Activities

During 2003-2004, the adolescent sexual health programs accomplished the following activities:

STARS

- 566 6th grade students received STARS.
- 25 STARS Teen Leaders were trained.

MARS

- 320 high school students received the MARS curriculum.
- The high school students who received the MARS curriculum demonstrate a 19% increase in knowledge of sexual health issues and local resources, according to an evaluation of the pre and posttests.
- 25 males received a MARS clinical appointment.

In addition, the Benton County Health Department received a 1.2 million dollar grant from the Office of Population Affairs to develop MARS into a science-based best practice for male reproductive health programming.

For 2004-2005, Adolescent Sexual Health activities in Health Promotion/Disease Prevention Program will include:

- Implementation of MARS
 - MARS clinical appointments
 - MARS curriculum in the Benton County and among culturally diverse populations
- Implementation of STARS in the middle schools in Benton County

Evaluation

The evaluation includes:

- Pre and posttests
- The number of individuals served
- Client satisfaction surveys

Chronic Disease Prevention

Current Condition or Problem

The Benton County Health Department provides technical assistance to community-based coalitions and coordinates and implements chronic disease prevention health promotion services, collaborates with other agencies and organizations to control, remediate, as well as prevent chronic diseases, and acts as a resource to the community on topics related to chronic disease prevention. Project areas include: Breast and cervical cancer prevention, diabetes prevention, and healthy weight and lifestyles promotion.

Activities

Healthy Weight and Lifestyles and Diabetes

- Implemented Walk to School Day (approximately 800 grade school students served)
- Implemented a worksite pedometer walking program that included 180 participants

- Implemented five “5-A-Day” Fruit and Vegetable promotions
- Provided technical assistance to the Healthy Weight and Lifestyles Coalition and the Benton County Diabetes Project.
- Implemented diabetes prevention education to 54 high risk Latinos
- Distributed 1,250 Living with Diabetes Resource Guide
- Implemented Meals Made Easy for Diabetes (27 participants)
- Implemented Chronic Disease Self-Management classes (14 participants)

Breast and Cervical Cancer Prevention

- Provided technical assistance to the Benton County Breast and Cervical Cancer Coalition.
- Provided early detection screening – mammogram voucher program to 76 low income women
- Provided breast health education outreach to 2002 Latino women.
- Convened a Asian Pacific Islander Health Council with 28 members
- Distributed 8,000 copies of Transitions
- Delivered a breast self examination training to 34 participants
- Delivered a Risk Management Strategies for Clinical Breast Examination CME Training to 75 participants

Please see attached Oregon Breast & Cervical Cancer Education Plan in Appendix D - the Appendixes document.

The activities for Chronic Disease for the 2004-2005 fiscal year will include the following:

- Technical assistance and administrative support for three coalitions – the Healthy Weight and Lifestyles Coalition, the Diabetes Coalition, and the Breast and Cervical Cancer Coalition.
- Community trainings on chronic disease prevention and breast and cervical cancer prevention.
- Community outreach and education on chronic disease prevention and breast and cervical cancer prevention.
- Coordination of the locally supported mammography screening program for low-income and uninsured women.

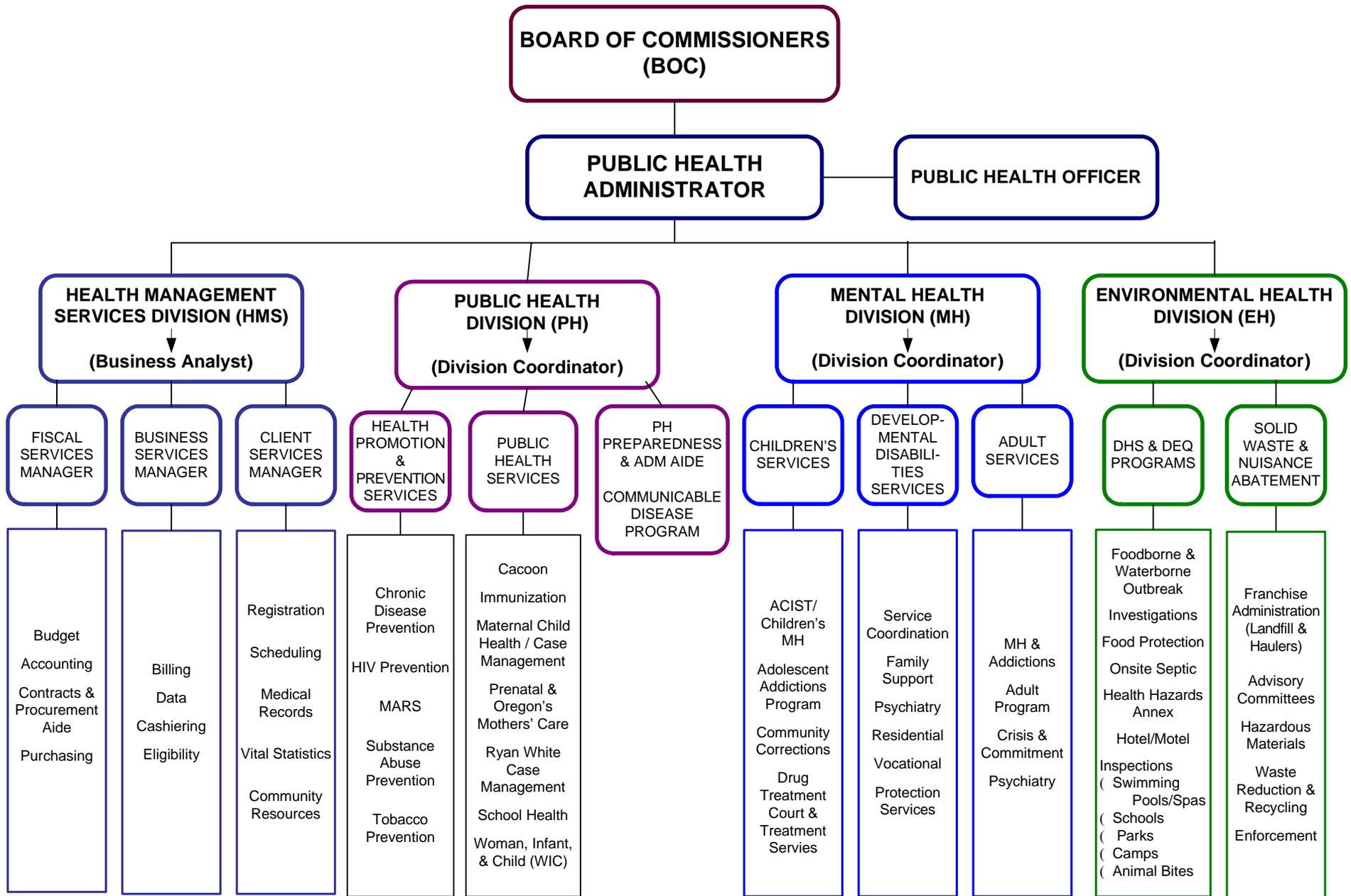
Evaluation

Evaluation for Chronic Disease consists of the following:

- Pre and posttests
- Number of people served
- Number of coalition meetings and number of people who attended
- Number of participants at community held events
- Surveys of group participants

BENTON COUNTY HEALTH SERVICES

Organizational Chart - Revised 11-14-07



V. UNMET NEEDS

The list of unmet public health needs in Benton County can be divided into two parts: Those which are occurring as a result of recent budgetary factors, and those which have never been appropriately addressed.

Environmental Health

West Nile Virus Prevention

Environmental Health programs have never been funded to provide community education or outreach for West Nile Virus or other mosquito-borne diseases. Limited state funding is available for testing for WNV, but no funds have been forthcoming to pay for staff time to process requests for investigation, make the determination if the bird meets the requirements for testing, collect and arrange for shipment or sample, and report test results to the client.

Update 2008-2009: No change

Update 2007-2008: No change

Update 2006-07: State and federal funding is still inadequate to provide appropriate levels of public education and WNV prevention activities.

Indoor Air Quality

No funding has been provided to address indoor air quality issues caused by mold or sick building syndrome.

Update 2008-2009: No change

Update 2007-2008: No change

Update 2006-07: Status unchanged. Corvallis, Philomath, and Monmouth school districts have become more active and have found no-cost options for assessing indoor air quality. They have partnered with the BCHD school nurses in this effort.

Services to Special Populations Including Minorities

Reductions in OHP coverage continue to affect the poorest and most disenfranchised portions of the population disproportionately. The Benton County population includes a rapidly growing number of Hispanics estimated at 4.7% (a percentage which has almost doubled from 1990 to 2000). However the percent

of Hispanics may be higher since the number of Hispanics was underestimated in the 2000 census because of literacy and language barriers and fears about revealing their immigration status. About 5,450 migrant and seasonal farm workers, who are primarily Hispanic, have been identified in the County.

Most of the Hispanic men are documented, but many have brought undocumented family members to the community. Many are employed in agriculture sectors that provide few or no employment benefits. The combination of poverty, geographic and cultural isolation, language and cultural barriers, and substandard living conditions put Hispanics at very high risk for poor health. The outcome of these risks is evidenced in poor nutrition, oral health problems, high rates of cardiovascular disease, and chronic diseases as elsewhere in the Country. Furthermore, the many barriers to obtaining services, including dental and mental health services, often result in waiting until health problems have become severe to seek care, making treatment more complicated.

An additional health care access issue in Benton County is that of Asian and other minority group members. Oregon State University is home to over 1,000 international students, many from Asian/Pacific and Middle Eastern nations. While most OSU students buy private insurance and can access services at the OSU Student Health Services, these services are limited to OSU students. A significant number of foreign students bring family with them, and these family members are often without insurance and hence without a primary health provider. Asian and Middle Eastern clients make up such a large part of Benton County Health Department's WIC enrollment that last year we translated our WIC nutrition educational information into Arabic. Multiple Chinese dialects and Korean are possible areas of service provision concern, also.

Update 2008-2009: BCHD continues to endeavor to increase the proportion of bilingual and bicultural staff. Public Health vulnerabilities among minority populations in Benton County continue to grow faster than the populations themselves.

Update 2007-2008: No changes – BCHD continues to increase the proportion of bilingual and bicultural staff.

Update 2006-07: An increasing proportion of BCHD staff is bilingual/bicultural. A new male bilingual/bicultural nurse practitioner is scheduled to join the clinical staff in summer 2006.

Update 2005-06: BCHD continues to expand its capacity to reduce disparities in healthcare provision. Several new bilingual/bicultural staff was added in business services, clinical, environmental, and public health.

Update 2004-05: Bi (and multi) lingual and cultural staff is increasingly recruited for BCHD positions. Additionally, our new single reception system helps to

provide a “no wrong door” approach to client services, reduce stigmatization, and improve program integration.

Services to the Elderly

Senior citizens (aged 65 and older) comprise 10.3% of the service area. The 75-84 age group grew 43%, and the 85 and older age group grew 47% in the past decade. These trends will generate additional special health care needs for Seniors, particularly in the small rural and isolated communities. Priority issues for Seniors include transportation, housing, health and wellness (particularly chronic disease prevention and control), loneliness and isolation, long-term care, and unemployment and finances. The lack of public transportation in the rural areas and other access issues make this group at risk for untreated health problems. An increasing number of Benton County’s elderly are becoming homebound and, thus, may not be accessing primary healthcare or receiving effective prevention education.

Update 2008-2009: No change, assessment & coordination with community partners continues.

Update 2007-2008: No change, assessment and coordination with community partners continues.

Update 2006-07: Assessment of the needs of Seniors in Benton County is underway.

Update 2005-06: Work on the Public Health Assessment and Plan was deferred when BCHD received notice of the FQHC grant. With the clinical program now separated from public health, work on the public health plan can proceed as outlined above. Update 2004-05: A comprehensive assessment of current health services for Seniors – both preventive and curative – as well as social support systems will be an integral part of our MAPP community assessment process. We recognize that the “demographic bulge” is an indicator of a number of impending challenges to public health. We hope that through the MAPP process we can better understand the coming challenges and position ourselves to respond to increased needs of an aging population in the coming decade.

Other

At present, injury prevention is uncoordinated in Benton County. Police departments, fire departments, schools, and community service organizations undertake pieces of effective injury prevention activities, but most of these efforts do not reinforce one another, and few even refer to drug and alcohol prevention, transportation safety, or mental health issues.

A priority of BCHD is to locate sustainable funding to employ an injury prevention specialist sited within our Health Promotion program. Such a program could model itself after alcohol and drug prevention. In addition to specific injury prevention curriculum offerings, this would help coordinate effective and consistent messages to address a wide variety of problems, which contribute to injury-causing behaviors. These include alcohol and drug use, mental health, tobacco use, maternal and child health and safety, harm reduction, transportation safety, and many more.

Update 2008-2009: No changes

Update 2007-2008: No changes

Update 2006-07: No changes from the previous year.

Update 2005-06: No changes from the previous year.

Update 2004-05: No resources for implementation of a comprehensive injury prevention program have yet been identified. Conservation of exiting services has been the priority.

Public Health Data Management

BCHD would like to find a way to better track primary prevention outreach activities. I am envisioning a database system similar to medical business informatics, but NOT using revenue collection opportunity as its service definition and measurement criteria.

We would like to have a system through which we can track the "productivity" of primary prevention staff according to time, specific type of intervention or activity provided, the numbers of clients in the intervention, as well as their general demographics. Since it is not for billing, we will not need the specific clients to be registered and will not need identifiable client information.

Existing practice management software system will not work – they are not designed to track pre and post-test scores, behavior change criteria, outreach presentation attendance and demographics, etc. We envision using something akin to a public health "encounter form" for data collection, similar to those used for clinical billing purposes but with our own codes, not ICD-9 codes.

Update 2008-2009: No changes.

Update 2007-2008: No changes, search for fiscal resources continues

Update 2006-07: No financial resources have been identified to allow for creation and maintenance of a Public Health services data management system.

VI. LPHA BUDGET ACCESS INFORMATION

The Benton County budget is available on the web at:

http://www.co.benton.or.us/admin/budget/document_index.php

Benton County operates under a biennial budget. Please look for the 2007-2009 Budget document.

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VII. Minimum Standards - Both

Agencies are **required** to complete this section.

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 No A Local Health Authority exists which has accepted the legal responsibilities for public health as defined by Oregon Law.
2. Yes No The Local Health Authority meets at least annually to address public health concerns.
3. Yes 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 Current local health department policies and procedures exist which are reviewed at least annually.
5. Yes No Ongoing community assessment is performed to analyze and evaluate community data.
6. Yes No Written plans are developed with problem statements, objectives, activities, projected services, and evaluation criteria.
7. Yes No Local health officials develop and manage an annual operating budget.
8. Yes No Generally accepted public accounting practices are used for managing funds.
9. Yes No All revenues generated from public health services are allocated to public health programs.
10. Yes No Written personnel policies and procedures are in compliance with federal and state laws and regulations.
11. Yes No Personnel policies and procedures are available for all employees.
12. Yes No All positions have written job descriptions, including minimum qualifications.

13. Yes No Written performance evaluations are done annually.
14. Yes No Evidence of staff development activities exists.
15. Yes No Personnel records for all terminated employees are retained consistently with State Archives rules.
16. Yes No Records include minimum information required by each program.
17. Yes No A records manual of all forms used is reviewed annually.
18. Yes No There is a written policy for maintaining confidentiality of all client records which includes guidelines for release of client information.
19. Yes No Filing and retrieval of health records follow written procedures.
20. Yes No Retention and destruction of records follow written procedures and are consistent with State Archives rules.
21. Yes No Local health department telephone numbers and facilities' addresses are publicized.
22. Yes No Health information and referral services are available during regular business hours.
23. Yes 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 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 No To preserve the confidentiality and security of non-public abstracts, all vital records and all accompanying documents are maintained.
26. Yes No Certified copies of registered birth and death certificates are issued within one working day of request.
27. Yes No 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.
28. Yes No A system to obtain reports of deaths of public health significance is in place.

29. Yes No Deaths of public health significance are reported to the local health department by the medical examiner and are investigated by the health department.
30. Yes No Health department administration and county medical examiner review collaborative efforts at least annually.
31. Yes No Staff is knowledgeable of and has participated in the development of the county's emergency plan.
32. Yes No Written policies and procedures exist to guide staff in responding to an emergency.
33. Yes No Staff participate periodically in emergency preparedness exercises and upgrade response plans accordingly.
34. Yes No Written policies and procedures exist to guide staff and volunteers in maintaining appropriate confidentiality standards.
35. Yes 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 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 No There is a mechanism for reporting communicable disease cases to the health department.
38. Yes 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 Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or communicable disease case received.

40. Yes 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 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 No There is a mechanism for reporting and following up on zoonotic diseases to the local health department.
43. Yes No A system exists for the surveillance and analysis of the incidence and prevalence of communicable diseases.
44. Yes 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 No Immunizations for human target populations are available within the local health department jurisdiction.
46. Yes No Rabies immunizations for animal target populations are available within the local health department jurisdiction.

Environmental Health

47. Yes No Food service facilities are licensed and inspected as required by Chapter 333 Division 12.
48. Yes No Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.
49. Yes No Training in first aid for choking is available for food service workers.
Note: We use to provide training when it was in the Food Safety Training Manual for Food Employees. DHS removed this section about a year ago. Environmental Health is now providing choking materials at our cost.
50. Yes No Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided. **Note: It is covered in our Food Handler training course, but not if you are looking for a specific class on that subject. We provide education during an outbreak investigation and on request from individuals.**
51. Yes No Each drinking water system conducts water quality monitoring and maintains testing frequencies based on the size and classification of system.
52. Yes No Each drinking water system is monitored for compliance with applicable standards based on system size, type, and epidemiological risk.

53. Yes No Compliance assistance is provided to public water systems that violate requirements.
54. Yes No All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken.
55. Yes No A written plan exists for responding to emergencies involving public water systems.
56. Yes No Information for developing a safe water supply is available to people using on-site individual wells and springs.
57. Yes No A program exists to monitor, issue permits, and inspect on-site sewage disposal systems.
58. Yes No Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.
59. Yes No School and public facilities food service operations are inspected for health and safety risks.
60. Yes 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 No A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste.
62. Yes No Indoor clean air complaints in licensed facilities are investigated. **Note: There is no funding source identified for EH involvement. Tobacco is referred to the Public Health Tobacco Specialist. School Nursing is doing limited indoor clean air work with the school districts. Most other indoor air complaints, "mold complaints," are referred to private industry.**
63. Yes No Environmental contamination potentially impacting public health or the environment is investigated.
64. Yes No The health and safety of the public is being protected through hazardous incidence investigation and response. **Note: We are involved if it concerns food establishments and drinking water. There is very limited involvement with meth labs and usually in support of local law enforcement in coordination with DHS. Other hazardous incidents, chemical spills, etc. are handled by first responders, typically police and fire.**
65. Yes 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.
66. Yes 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 No Culturally and linguistically appropriate health education components with appropriate materials and methods will be integrated within programs.
68. Yes No The health department provides and/or refers to community resources for health education/health promotion.
69. Yes No The health department provides leadership in developing community partnerships to provide health education and health promotion resources for the community.
70. Yes No Local health department supports healthy behaviors among employees.
71. Yes No Local health department supports continued education and training of staff to provide effective health education.
72. Yes No All health department facilities are smoke free.

Nutrition

73. Yes No Local health department reviews population data to promote appropriate nutritional services.
74. The following health department programs include an assessment of nutritional status:
- a. Yes No WIC
 - b. Yes No Family Planning
 - c. Yes No Parent and Child Health
 - d. Yes No Older Adult Health
 - e. Yes No Corrections Health
75. Yes No Clients identified at nutritional risk are provided with or referred for appropriate interventions.
76. Yes No Culturally and linguistically appropriate nutritional education and promotion materials and methods are integrated within programs.
77. Yes No Local health department supports continuing education and training of staff to provide effective nutritional education.

Older Adult Health

78. Yes No Health department provides or refers to services that promote detecting chronic diseases and preventing their complications.
79. Yes No A mechanism exists for intervening where there is reported elder abuse or neglect.
80. Yes 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 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.

Parent and Child Health

82. Yes No Perinatal care is provided directly or by referral.
83. Yes No Immunizations are provided for infants, children, adolescents and adults either directly or by referral.
84. Yes No Comprehensive family planning services are provided directly or by referral.
85. Yes 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 No Child abuse prevention and treatment services are provided directly or by referral.
87. Yes No There is a system or mechanism in place to assure participation in multi-disciplinary teams addressing abuse and domestic violence.
88. Yes No There is a system in place for identifying and following up on high risk infants.
89. Yes No There is a system in place to follow up on all reported SIDS deaths.
90. Yes No Preventive oral health services are provided directly or by referral.

91. Yes No Use of fluoride is promoted, either through water fluoridation or use of fluoride mouth rinse or tablets.

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

Primary Health Care

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

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

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

96. Yes No Primary health care services are provided directly or by referral.

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

98. Yes No The local health department advocates for data collection and analysis for development of population based prevention strategies.

Cultural Competency

99. Yes No The local health department develops and maintains a current demographic and cultural profile of the community to identify needs and interventions.

100. Yes 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.

101. Yes No The local health department assures that advisory groups reflect the population to be served.

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

Health Department Personnel Qualifications

103. **Yes No** The local health department Health Administrator meets minimum qualifications:

A Master's degree from an accredited college or university in public health, health administration, public administration, behavioral, social or health science, or related field, plus two years of related experience.

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

104. **Yes 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.

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

105. **Yes 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.

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

106. **Yes 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.

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

Attachment A
FY 2008-2009 WIC Nutrition Education Plan
Goal 1, Activity 3
WIC Staff Training Plan – 7/1/2008 through 6/30/2009

County/Agency: Benton County WIC
Person Completing Form: Leslie Redpath
Date: 4-15-2008
Phone Number: 541-766-6173
Email Address: leslie.r.redpath@co.benton.or.us

Staff Development Planned

Based on planned new program initiatives (for example Oregon WIC Listens, new WIC food packages), 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, 2008 – June 30, 2009. State provided in-services, trainings and meetings can be included as appropriate.

Quarter	Month	In-Service Topic	In-Service Objective
1	July-September 2008	1) Baby-led Breastfeeding (Maryam Jones, WIC Nutrition Educator) 2) Review Oregon WIC Key Nutrition Messages (Staff) 3) Review Diet Assessment from DR Module to identify training needs (Staff) 4) Review and evaluate results of staff pedometer activity & participant-free pedometer activity. (Staff)	1) To improve breastfeeding outcomes Maryam will introduce WIC staff to information from Statewide Meeting on Baby-led Breastfeeding. 2) To identify any additional training needs. 3) Group discussion will identify any additional training needs and will schedule if needed. 4) To identify successes of staff and client pedometer activities.

2	October-December 2008	<ol style="list-style-type: none"> 1) Ways to increase calories for underweight infants and children not gaining weight or losing weight. (Inge Daeschel, RD) 2) Staff evaluation of how their modifications since new NR and DR Modules have modified their approach to counseling (Staff) 3) Quality Controls and Hemoglobin procedure review (Roxanne Simi, Lab Lead) 	<ol style="list-style-type: none"> 1) Provide staff with techniques and tools to assist participants to make actual dietary changes that the RD is providing to enable staff to reinforce key messages RD provides at appointments and for clients needing but refusing RD visits. 2) Can use state provided assessment tools or discuss as a team. 3) Annual competency training and review.
3	January-March 2009	<ol style="list-style-type: none"> 1) Efficient techniques for motivating participants to make lifestyle changes to prevent obesity. (Inge Daeschel, RD) 2) Review food package changes (Staff) 3) Confidentiality In-service/forms (Leslie Redpath) 	<ol style="list-style-type: none"> 1) Provide staff with efficient techniques and tools to motivate participants to make lifestyle changes to reduce their risk of obesity. 2) Select 3 food package modifications and identify related Key Nutrition Ed messages to use or modify.
4	April - June 2009	<ol style="list-style-type: none"> 1) Civil Rights Training for 2008 (Leslie Redpath) 2) Cultural Competency Training (County Health Department) 	<ol style="list-style-type: none"> 1) Review Civil Rights requirements. 2) Review and meet County and State WIC requirements.

APPENDIX B

Local Health Department: _____

Plan A - Continuous Quality Improvement: _____

Fiscal Years 2006-2008

Year 1: July 2005 – June 2006				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results ¹	Progress Notes ²
A. To increase the number of immunizations given in the CHC clinic.	<ul style="list-style-type: none"> Assess baseline data for year 2004- how many immunizations given at CHC clinic visits. Educate providers on all aspects of the administration of immunization. Immunization coordinator will provide the training or request assistance from OHD to help train the providers. Implement change. 	<ul style="list-style-type: none"> At the end of FY 2005, request an AFIX report for BCHD CHC clinic providers. 2 Nurses will be trained and administering immunization to clients receiving care at CHC. Policy and procedure written for screening CHC clients about their immunization status. 	FY 2006 Report <ul style="list-style-type: none"> AFIX was not generated due to the fact that it is not possible to separate the public health immunizations from the CHC. A separate designation code has been requested from the State Immunization program. 2 Nurses were trained and have been administering some immunizations in the 	FY 2006 Report <ul style="list-style-type: none"> Need to contact Nathan Crawford about the designation numbers and then learn how to pull reports for the CHC sites. Initial training has been completed. CHC staff will be part of the group that will be invited to our Immunization update

¹ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

² **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

	<p>in immunization practice (i.e. routine screening at each visit). Possibly use IRIS to forecast shots.</p>		<p>CHC. A coding training is scheduled for April 19th to review the data entry piece of immunization (state staff will be giving the training).</p>	<p>trainings.</p> <ul style="list-style-type: none"> • As of this date, there has not been a process initiated that would include screening for immunizations in clients attending the CHC. This will be put into next year's outcome measures.
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<p>B. To provide Hep. A/B vaccine for target populations.</p>	<ul style="list-style-type: none"> • Develop a system to provide Hep. A/B to the high-risk clients in the county jail or who are participating in the Parole and Probation (P&P) program or being seen at the Community Health Center (CHC). • Identify the nurse who will provide the Hep. A/B and who will develop a system for recall for the completions of the series. 	<p>20 clients who are either in jail or in P & P will receive their Hep. A/B immunizations.</p>	<p>FY 2006 Report</p> <p>Plan to involve just jail and parole and probation was expanded to include IV drug users at needle exchange sites. New Beginnings is a drug recovery program which is court mandated. Clients are followed through that program for the completion of vaccine series.</p> <p>The number of clients served 7/1/05 through 4/19/06 is 54 with the total of vaccine doses received by these clients being 81.</p> <p>Recall method for vaccines given at needle exchange sites is coupon with the date and time of the second-dose clinic.</p>	<p>FY 2006 Report</p> <p>Completed. Exceeded projections.</p>
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Plan A - Continuous Quality Improvement: _____

Year 2: July 2006 – June 2007				
Objectives	<u>Methods / Tasks</u>	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
A. Increase the number of immunizations from that given in FY 2005 by 50%.	<ul style="list-style-type: none"> • Provide AFIX reports to show providers how they are doing regarding immunizing the clients they are seeing in FY 2006. 	<ul style="list-style-type: none"> • Obtain separate designations for the 3 CHC clinics. • Obtain 2006 baseline data for shots given in each of these clinics. 	<p>Designations were obtained for each of the CHC clinics.</p> <p>Baseline data was collected for each of the CHC sites.</p>	<p>Obtained data from IRIS after receiving separate designation sites for the 3 CHC clinics. This is the first data available so a comparison could not be made to that of 2006. Baseline date as of 6/29/07</p> <p>Benton Family Practice- 280 doses Lincoln Family Practice- 206 doses Monroe Family Practice- 107 doses</p>

¹ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

² **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

<p>B. Increase the number of the target population clients receiving Hep. A/B vaccine by 5-10% from number served in FY 2006. Increase the number of clients receiving two or more doses of vaccine.</p>	<ul style="list-style-type: none"> • Nurse will develop a system to identify new clients in jail, P& P, and CHC. • Nurse will utilize the recall system she/he developed in 2005. 	<ul style="list-style-type: none"> • 55-60 clients will have received at least 1 Hep. A/B while in jail or P & P, at needle exchange sites or during CHC visit. 40% of these clients will receive two or more doses. 	<p>Objective met:</p> <p>69 clients were given Hep A/B at the Drug/Alcohol treatment center. Of these 69 doses, 67% (46 doses) were the clients receiving 2 or more doses.</p> <p>Thus, the number of clients served at the end of 2007 revealed an 8% increase from the end of fiscal year 2006. The percent of clients receiving more than the initial shot increased by 27% from fiscal year 2006.</p>	<p>Successful program which will continue next year.</p>
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Plan A - Continuous Quality Improvement: _____

Year 3: July 2007 – June 2008				
Objectives	<u>Methods / Tasks</u>	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
<p>A. 80% of the clients that attend CHC will have an up-to-date immunization status.</p>	<ul style="list-style-type: none"> • Audit charts for immunization data and determine if immunizations are up to date. • Develop a recall system for clients that are NOT up to date with their immunizations. 	<ul style="list-style-type: none"> • Compare 2006 Immunization data from the 3 CHC clinic sites with 2007 data. • IRIS reports by provider to help them look at missed opportunities. • Report of clients' immunization status that will reflect 80% of them are up to date. 	<p>Chart audits for immunization data is awaiting the transition to Electronic Medical Records in CHC. A recall system can be developed at that time. EMR is currently being implemented in CHC clinics. IRIS training has been given for a staff person from each clinic site so they can check for missed opportunities and run other reports.</p>	<p>As an interim measure, the Clinic Nurse Manager has instituted a sticker system for the Progress Notes of each chart to remind the provider to assess and discuss immunizations at each visit.</p> <p>The number of providers in CHC clinics has increased. Comparison of immunizations given for 2007-2008 period will be run the end of June and reported on the next comprehensive plan.</p>

¹ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

² **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

<p>B. Increase the number of target population clients receiving Hep. A/B immunizations by 5-10% over FY 2007. Increase the number of clients receiving 2 or more doses of vaccine.</p>	<ul style="list-style-type: none"> • Revise the system for the identification and recall of target population for the administration of Hep. A/B. • Develop outreach activities to improve completion of Hep. A/B. 	<ul style="list-style-type: none"> • 60-65 new clients from the target population will receive at least one Hep. A./B. vaccine. • 50% of target population to complete two doses of Hep. A/B series. 	<p>A tracking system was devised for follow up of the target population from New Beginnings, Needle exchange site.</p>	<p>Client contact, follow up through New Beginnings drug rehab program at program site 4-5 times per year. Good communication with BC Jail Nurse provided f/u when clients incarcerated or released from Jail. Needle exchange health educator transported clients to clinic for HVC screening and vaccination and follow up. STD clients referred for vaccination and scheduled follow up. Numbers of clients and % completing two doses of Twinrix will be available the end of June and reported on the next comprehensive plan.</p>
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Local Health Department:
Plan B - Chosen Focus Area:
 Fiscal Years 2006-2008

Year 1: July 2005 – June 2006				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results ¹	Progress Notes ²
A. Community-wide AFIX Project. Identify the private providers who utilize AFIX reports.	<ul style="list-style-type: none"> Recruit providers to participate in AFIX assessments at our local Immunization Advisory Board meeting. Provide meetings for feedback sessions on AFIX. 	<ul style="list-style-type: none"> 90% of private providers have been given information about AFIX reports. 20% of the private providers have requested their own AFIX reports. 	FY 2006 Report All private providers have received information about AFIX in the past. Representatives of three (50%) of private provider practices attended our last Immunization advisory board meeting and received additional encouragement to utilize this service. Two private practice groups requested AFIX reports in 2005. So far, one additional practice has requested an AFIX report in calendar year	FY 2006 Report Complete Complete

¹ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

² **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

			2006.	
B.			To be completed for the FY 2006 Report	To be completed for the FY 2006 Report

Plan B - Chosen Focus Area: _____

Year 2: July 2006 – June 2007				
Objectives	<u>Methods / Tasks</u>	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
A. 40% of the private providers have started requesting AFIX reports.	<ul style="list-style-type: none"> • Host an AFIX Exchange during our Immunization Advisory Board meeting by inviting the AFIX staff person from the State Health Division to review and answer questions. • Participate in feedback sessions. • Assist providers in development of policies based on AFIX results. 	<ul style="list-style-type: none"> • Providers (40%) will utilize AFIX reports to develop new policies to increase their immunization rates. 	<p>AFIX reports were provided to 7 of the 8 providers in Benton County. It was not determined whether the providers developed policies or practices as revealed by these reports.</p>	<p>BCHD hosted an Immunization Advisory Board meeting. We invited all of the private providers and only 1 provider showed up for the meeting. The reports were distributed to the remaining practices by our Immunization Coordinator. Changes in their immunization Policy and Procedures could be revealed in the 2007-08 AFIX reports.</p> <p>Need to obtain this data next fiscal year from our Immunization Consultant.</p>

¹ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

² **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

B.			To be completed for the FY 2007 Report	To be completed for the FY 2007 Report
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Plan B - Chosen Focus Area: _____

Year 3: July 2007 – June 2008				
Objectives	<u>Methods / Tasks</u>	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
A. 50% of the private providers have started requesting AFIX reports.	<ul style="list-style-type: none"> • Survey the private providers: <ul style="list-style-type: none"> a) they requested AFIX reports and/or consultation from State Health Division b) were new policies/procedures developed during 2007-08 to increase their immunization rates. • Annual AFIX report –compare with previous year’s data. 	<ul style="list-style-type: none"> • Providers (30%) will request AFIX reports. • Immunization up-to date rates as reported by AFIX for private providers will increase by 5% for fiscal year 2007-08. 	A letter was sent to all private providers inviting them to utilize the Oregon AFIX program for the purpose of identifying missed opportunities, improving immunization rates.	No AFIX reports have been requested since this mailing. One provider did request a report earlier in 2007.

¹ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

² **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

B.			To be completed for the FY 2008 Report	To be completed for the FY 2008 Report
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Local Health Department: _____
Outreach Activities: July 2005 – June 2006

Activity 1:				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
A. Inform parents and educators about the school immunization requirements in 3 out of the 4 school districts.	<ul style="list-style-type: none"> To present the immunization requirements for school entry at the kindergarten level during kindergarten round-up programs. 	<ul style="list-style-type: none"> Presentations at 3 different districts at their spring kindergarten orientation programs about school immunization requirements. 	FY 2006 Report Completed	FY 2006 Report
Activity 2:				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
A. Determine a new outreach strategy to improve immunization rates in the WIC program in Benton County.	<ul style="list-style-type: none"> Meet with the WIC program to figure out how better to encourage WIC clients to immunize their children. Determine the number of children 	<ul style="list-style-type: none"> One new outreach immunization strategy developed and implemented in the Benton County WIC program. 	FY 2006 Report Completed and in progress	FY 2006 Report With Year End Immunization funding-hired an intern who is looking up WIC children in the ALERT

¹ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

² **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

	<p>who are not up to date with their immunizations.</p> <ul style="list-style-type: none"> • Provide the new outreach activity to WIC children who have insufficient immunization status. 			<p>system, then a nurse does a forecast of shots needed since public entities do not have access to this function in ALERT. Finally, the last step is determining the children who are not up to date with their immunizations, and the student intern makes a personal phone call to give parents this information. If they do not have a provider, she informs them of the option of obtaining immunizations through Benton County Health Department. It will be wonderful once IRIS and TWIST connect and the WIC certifiers can give this information. I hope for more year-end immunization monies so we can continue this process.</p>
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EXAMPLE

Local Health Department:

Continuous Quality Improvement: *Missed Opportunities rate with private partner*

Fiscal Years 2006-2008

Year 1: July 2005 – June 2006				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
I. Partner with 1 private provider to create and implement a plan to reduce missed opportunity rate in their practice by 5% over 3yrs.	Assess practices: <ul style="list-style-type: none"> Assess policy and consistency of screening children for needed shots. Share strategies to improve missed opportunity rate. 	<ul style="list-style-type: none"> Determine baseline measure of percent of children routinely screened. Determine baseline measure of missed opportunity rate by September 2005. 	To be completed for the FY06 Report	To be completed for the FY06 Report
	Develop plan: <ul style="list-style-type: none"> Develop protocol to screen every child at every visit to clinic. Provide training to staff on TRUE contraindications. Display Contraindication & Precautions poster in exam rooms. 	<ul style="list-style-type: none"> Develop a plan by Nov. 2005. Document 80% of clinical staff trained in TRUE contraindications. 	To be completed for the FY06 Report	To be completed for the FY06 Report

¹ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

² **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

Year 2: July 2006 – June 2007				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results ¹	Progress Notes ²
<p>II. Evaluate partnership with private provider to improve plan to reduce missed opportunity rate in their practice by 5% over 3 years.</p>	<ul style="list-style-type: none"> • Reassess consistency of screening children for needed shots. • Evaluate clinical staff's understanding of TRUE contraindications. • Identify new intervention to start. 	<ul style="list-style-type: none"> • Measure 10% improvement in percent of children routinely screened. • Missed opportunity rate decreased by 3%. • Decide efficacy of continuing plan in the next year. 	<p>Data for comparison was not available from private providers regarding number of children routinely screened and rate of missed opportunities.</p> <p>Aggregate data of all of the Benton County providers revealed that the average up-to-date rate for clinics was 54%.</p> <p>The average missed opportunity shot rate among providers was at 38%.</p>	<p>After obtaining and becoming more aware of our private provider averages, a plan will be put into place for future years to improve on both of these areas.</p>

¹ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

² **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

Year 3: July 2007 – June 2008

Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results ¹	Progress Notes ²
<p>III. Reevaluate Partnership with 1 private provider to improve plan to reduce missed opportunity rate in their practice by 5% over 3 years.</p>	<ul style="list-style-type: none"> • Focus on Philomath Family Medicine. <ul style="list-style-type: none"> a) Provide training on true contraindications. b) Provide consultation as requested after training. 	<ul style="list-style-type: none"> • Complete workshops by October 1, 2007. • Missed opportunity rate decreased by 2%. 	<p>Focus shifted from Philomath Family Practice to Corvallis Family Practice. We worked with the new office manager of this practice to ensure an emergency back-up plan for vaccine protection.</p>	<p>Staffing capacity necessitated a shift of emphasis from private provider training to working with the Benton Family Practice, Lincoln, and Monroe Community Health Centers to improve staff training regarding vaccine management, VFC coding and reducing missed opportunities. Also participated in setting up a new Delegate Agency site at East Linn Clinic.</p>