

BAKER COUNTY HEALTH DEPARTMENT

**2008 – 2011
Comprehensive Plan**

I. Executive Summary

Baker County Health Department (BCHD) continues to provide essential public health services of epidemiology and control of preventable diseases, maternal and child health services, family planning, collection and reporting of health statistics, health information and referral services. Other services that we provide include dental varnish to pediatric clients, emergency preparedness, health education and promotion. Tobacco, Healthy Start, and Sexual Assault Nurse Examiner (SANE) are new programs at BCHD, beginning in the 2008-2009 fiscal year.

The BCHD staff includes 15 staff members consisting of an administrator, health officer, nurse practitioner, nursing supervisor, registered dietitian, four registered nurses, and seven support staff. Two of the registered nurses have completed SANE training and received certification. We are committed to cross training staff in essential services to build surge capacity. Our main focus on building surge capacity continues in public health preparedness. Responding to H1N1 has strengthened our planning efforts and engagement of community partners. We realize that a continued focus on public health preparedness will be necessary due to the possibility of a reoccurrence of a novel disease.

In reviewing the BCHD 2008 Comprehensive Plan, the current data is similar to the 2008 assessment. However, BCHD had increased reports of communicable diseases last year. Seventy-eight reports were made to Department of Human Services (DHS). The prior year, 41 reports were completed. The most prevalent reported disease remains Chlamydia and Hepatitis C. Programs recently added to BCHD is the Tobacco program that has increased community partnerships through required activities. We are now conducting SANE exams by certified registered nurses. This has also supported relationships with law enforcement agencies, the local hospital and district attorney's office. Healthy Start was added to BCHD July 2008 which has provided an opportunity to promote parent child relationships and decrease child abuse in our county.

The 2009-2010 budget has been submitted and is approved by the Baker County Board of Commissioners. We continue to rely on state and county general fund dollars to provide public health services to our community.

The 2009-2010 Annual Plan is written in blue to show updates to the 2008 Comprehensive Plan.

II ASSESSMENT

Baker County is located in eastern Oregon and consists of 3,089 square miles. It is bounded to the north by Union and Wallowa Counties, to the west by Grant County, and to the south Malheur County. The area includes the Powder River and the Wallowa Mountains. Baker County was established in September 22, 1862. The average temperature in January is 25.2 degrees Fahrenheit and in July 66.6 degrees Fahrenheit. The chief economic bases are agriculture, forest products, manufacturing and recreation. Recreation includes, the Oregon Trail Interpretive Center and Old Oregon Trail, Sumpter Gold Dredge Park, Sumpter Railroad, Baker City Restored Historic District, various ghost towns, spectacular camping and hiking wilderness areas.

The most recent county estimate data of 2007 lists Baker County as having a population of 16,435. We have experienced a 1.8 decrease from 2000. The largest city in the county is Baker City that has a population of 10,105, an increase of 225 residents since 2000. Approximately 6,330 people live in rural areas of the county. Census data shows the population has remained consistent with approximately 49% male and 50% female. Age distribution is as follows; 0-19 year olds 4,427, 20-39 year olds 3,244, 40-64 year olds 5,885, and residents 65 and older account for 3,185 living in Baker County. [According to 2008 data, our population has remained similar to the 2008 assessment. The total population for Baker County remains at 16,455 people. Baker City continues to be the most populated city in Baker County with 10,140 residents.](#)

The 2006 US Census Bureau describes the Baker County population consisting of predominately Caucasian 93.4%, Persons of Hispanic or Latino origin 3.2%, American Indian and Alaska Native 1.3%, Asian persons 0.6% and African American 0.3%.

The percentage of Baker County foreign-born persons is 1.8%. High school graduates account for 80.3% of the population. Persons with a bachelor's degree or higher, account for 16.4% of the population. Approximately 3,748 of people 5 years and older have a disability.

The Bureau of Labor Statistics describes Baker County as 1 of 16 severely distressed counties in Oregon. The 16 severely distressed counties are defined as rural. The per capita personal income is \$24,199. Large disparities continue to exist between Oregon counties. An example of a disparity is the Baker County median household income of \$32,500 and the Clackamas County median household income of \$54,743. The percentage of persons below poverty is 15.2% of the population.

Births

The number of Baker County resident births occurred as follows; 2004 = 151 births, in 2005 = 165 births and 2006 = 170 births. In 2006, six infants were born to mothers between the ages of 10-17. Twelve infants were born to mothers between the ages of 18-19, and 152 infants were born to mothers 20 and older.

Seventeen low birth weight infants were born in 2006 or 10% of total births of 2006. This exceeds the Oregon state average of 6.1%. Of the 170 births, 139 women received prenatal care in the first trimester, 82.7% compared to 79.2% of the state average. In 2006 91.7% of pregnant women received adequate prenatal care, the state average is 93.8%. Payment sources the infants born to mothers in 2006 include, 62 private pay, eight self-pay and 93 covered by the Oregon Health Plan.

Induced abortions for women who reside in Baker County in 2006 preliminary data shows 12 induced abortions, and in 2007 preliminary data shows six induced abortions.

The 2008 data shows that total births were 167, of these, 63 were first births. Women ages 20 years old and higher, gave birth to 147 of these infants.

Deaths and Causes of Death

In 2005 total deaths that occurred in Baker County is 255, three of these deaths occurred in infants less than one year old. The median age of death is 79. Life expectancy at birth is 77.1 years. The preliminary data of 2008 of total deaths in Baker County is 168. Of this total, 149 were of natural cause. Residents ages 65 and older experienced the highest number of 125 deaths during this period of time.

The leading cause of death is cancer, second leading cause of death is heart disease and the third leading cause of death is chronic lower respiratory disease. Deaths due to alcohol or drug use in 2005 totaled 11; seven of these were from chronic alcoholic liver disease. Of the 255 deaths, 54 or 21% were tobacco linked. The state average of tobacco linked deaths in 2005 is 22%.

Dental

BCHD has taken a collaborative approach in determining unmet dental needs in Baker County. Dental uninsured rates are 10.3% higher than the state average, only two dentists accept Oregon Health Plan clients. Dental visits to the local emergency department were 2.6 times greater than national trends between 2002-2006. In 2007, BCHD, the medical and dental community developed a partnership with the Oregon Rural Practice-based Research Network (ORPRN) and the OHSU Practice-based Research in Oral Health (PROH) began a collaboration to identify local oral health challenges. A new dentist has opened a clinic in Baker County and accepts Oregon Health Plan patients which has been helpful in decreasing barriers to receiving dental care. We continue to refer all clients needing services to local providers.

Diabetes

The Behavioral Risk Factor Surveillance System reports that 8.5% of adults were told by a doctor that they have diabetes. Management of diabetes occurs in the primary care setting. Diabetic education involves diet plans, exercise and follow-up.

Communicable Diseases

BCHD continues to have low communicable disease occurrence rates. In 2006, BCHD completed 38 case investigations involving communicable disease and sexually

transmitted infections. Of the 38 cases investigated, Chylamydia occurred most frequently, followed by West Nile Virus, and Campylobacteriosis. In 2007, communicable disease case counts remain similar to the 2006 data, with the exception of a decrease in West Nile Virus cases. BCHD has not had a case of active mycobacterium tuberculosis in recent years. [BCHD has experienced increased rates of communicable disease. During this fiscal year, we've submitted 78 reports of disease. Chlamydia and Hepatitis C are the most reported diseases in Baker County.](#)

Immunizations

BCHD remains the primary provider of immunizations in Baker County. Primary care providers provide travel vaccines. In the past, primary care providers and our local hospital provided flu vaccine to the community. Often times these doses were provided on a donation basis, people who could not afford to pay for the vaccine, were still administered a dose. Currently, less providers are offering flu vaccine due to cost of purchasing the vaccine and availability concerns. It is uncertain if primary care providers will continue to provide flu vaccine in the future. There is a growing dependence on BCHD to provide flu vaccine, especially to high risk populations. BCHD relies on state supplied vaccine due to the high cost. The DHS Immunization Program provides approximately 70% of vaccine administered by BCHD. This has given us a significant opportunity to protect our community providing flu vaccine and also to practice emergency preparedness plans. We hope to continue this practice in the future. [The 2008 data shows that 78% of children are up-to-date or late up-to-date. BCHD currently serves 95% of children 12-35 months of age residing in our county. It has been our experience that an increased number of parents are declining to fully immunize their children due misinformation they have received from outside the medical community.](#)

Tobacco Use

The percent of adults who smoke cigarettes in Baker County is 23%, exceeding the state at 20%. In addition, the percentage of babies born to women who smoked while pregnant is 25% in Baker County, exceeding the state at 12%.

82% of Baker County residents believe that people should be protected from secondhand smoke. The Oregon's Smokefree Workplace Law does not protect approximately 150 employees working in Baker County.

[According to the Oregon Tobacco Prevention and Education Program 2009 data, 2,601 adults regularly smoke, 880 people suffer from a serious illness caused by tobacco use. Forty-five people die from tobacco use \(21% of all deaths in this county\). Over seven million dollars are spent on medical care for tobacco-related illnesses.](#)

Adequacy of Essential Public Health Services:

Epidemiology and control of preventable diseases and disorders

BCHD is committed to providing epidemiology and control of preventable diseases. Our focus has been on increasing surge capacity among staff, developing our policies, engaging our community and community partners through exercises and education.

Many of our staff members have completed communicable disease classes provided by DHS and ICS training provided by FEMA. We have 90% of BCHD staff participate in exercises. We are committed to providing training and education to assure competency in disease response.

We have engaged our community partners in compliance with disease reporting by providing education with the assistance of DHS.

In 2007 we have completed greater than 200 community outreach activities pertaining to disease prevention and education. We speak to our adolescent population in schools, travel to drug and alcohol treatment centers on a weekly basis and provided education to various public and private community partners. [Outreach activities continue throughout our community by staff members. Presentations at drug and alcohol treatment centers continue twice monthly.](#)

Parent and child health services, including family planning

BCHD provides Family Planning, Oregon Mother's Care, Babies First, CaCoon and Immunization services to our community. [BCHD has added the Healthy Start program to assist in reaching first birth families. Through this program, we have been able to provide additional services and resources to Baker County families.](#)

The BCHD Family Planning program serves 60.1% of women in need in the county. Of the clients served, 52.8% are uninsured for primary care and 8.5% of clients are unsure of their insurance status. In addition, 2006 data shows that 90.4% of clients receiving services were below 150% of the federal poverty level. A total of 128 pregnancies among 426 female clients were averted. [Current data shows that BCHD serves 54.6% of women in need \(WIN\). The state average is 55.2%. We have experienced reduced client numbers of 16 WIN in our service area. The BCHD staff members are committed to reaching all WIN in Baker County and are developing outreach activities.](#)

The BCHD Immunization program remains the main immunization provider in Baker County. In 2007, we served 90% of children age's 0-36 months. Of these children, 81% have completed the 431331 series. During the past few years we have exceeded the Oregon State average immunization rate. We have received numerous awards that reflect the BCHD team's hard work and dedication. These awards are: "Highest Percentage of Fully Immunized Two-Year Olds among Oregon's Local Health Departments in 2005", "Certificate of Achievement in Public Health for having the Highest Percentage of Two Years Olds Fully Vaccinated in 2006", and a "Certificate of Achievement in Public Health for reaching the National Healthy People 2010" goal of having at least 80% of two year olds fully vaccinated. We have been selected to receive an OPIC award April 2008. [BCHD provides immunizations to 95% of children ages 12 months to 35 months of age. The current rate is 78% who has completed the 431331 series.](#)

The BCHD team has completed greater than 80 travel immunization clinics in 2007. These clinics were held within Baker City and in the far-reaching rural areas of Baker County. Travel clinics include a partnership with a local physician's clinic, exclusion clinics, school registration clinics and travel flu clinics. The community is supportive of BCHD new leadership role. [Travel clinics throughout Baker County continue as in 2007. We have increased flu vaccination travel clinics to local businesses.](#)

BCHD WIC program served 856 women, infants and children in 2007. This is a 4% increase from 2006. WIC is maintaining caseload (478) at target. A new addition to WIC services is providing walk-in clinic days. Clients find value in this arrangement and barriers are decreased. In addition, our WIC staff consists of a part-time registered dietitian. WIC staff has completed outreach activities regarding breast-feeding and nutrition within Baker County. We are in the process of cross-training non-WIC staff to provide additional support.

The BCHD Babies First and CaCoon programs have a significant increase in client visits. We have focused our attention on supporting and training our MCH staff. In addition, an outcome of our work is an increased awareness of the BCHD MCH programs within the Baker County medical community. We are experiencing increased referrals and collaboration from medical offices and our local hospital. We conduct outreach activities to the local Drug and Alcohol treatment center that provides services women in treatment and their children. [We provide outreach to expectant parents on a quarterly basis at our local hospital, St Elizabeth Health Services.](#)

Collection and reporting of health statistics

BCHD provides vital statistics services including birth and death recording and registration. Birth certificates are received from our local hospital, St Elizabeth Health Services. Death Certificates are received by hard copy and electronically. We work with Coles Funeral Home, Gray's West & Company Pioneer Chapel and Funeral Home and Tami's Pine Valley Funeral Home. Vital records staff include registrar and deputy registrar, both staff members are full-time employees. [We are cross training additional staff to support surge capacity and developing policies. One of Baker County's largest physicians office now submits electronic death certificates and two of the funeral homes have requested secondary terminals. Our focus has been to increase the use of electronic death certificates through our local partnerships.](#)

Health information and referral services

BCHD gathers health information and referral resources on an ongoing basis. Resources are gathered and retained in a database. Information is printed and given to clients seeking services. Examples of resources include contact information of local physicians, dentists, food banks, Oregon Health Plan, and counseling services. Frequently clients are referred from other providers to BCHD for resources. In addition, clients receiving BCHD services are screening for needing primary care and resources are given as

appropriate. [We are in the process of updating Oregon SafeNet to reflect resources within Baker County.](#)

Environmental health Services

Environmental services are provided to Baker County by Malheur County Environmental Health. Some of these services include restaurant facility inspections, mobile and temporary food operations, swimming pool inspections and review of client complaints. BCHD has developed a communication tool for food service complaints to assist in tracking and follow-up.

Adequacy of Program Services

Dental

BCHD has implemented a dental varnish program and offers Bi-monthly dental varnish clinics to the pediatric community. In addition, dental varnish services are offered to clients enrolled in the Babies First and CaCoon program. We conducted a press release with our local newspaper stating the availability of the service and benefits.

Emergency Preparedness

BCHD staff continues to develop and implement emergency response plans and conduct exercises. Increased staff members have participated in training and competency towards public health emergency response. We continue to collaborate with counties in our region and involve local partners such as Baker County Emergency Management. We have conducted exercises involving the medical community and other emergency response staff. [BCHD has continued to involve community partners with preparedness work, this includes exercises. Activities involving H1N1 has brought many new partners seeking assistance and planning.](#)

Health Education and Promotion

BCHD is active in promoting health education and disease prevention activities to the community. We conducted numerous educational activities on topics that pertain to public health services. These include collaboration with DHS to provide education involving rabies with law enforcement, family planning topics of coercion and birth control methods, pandemic flu presentations and sexually transmitted disease prevention topics to local drug and alcohol facilities. In addition, we conduct presentations at local schools. BCHD has established a close working relationship with the local newspaper and have press releases prepared.

Laboratory Services

BCHD currently utilizes Interpath laboratory located in Baker City and regionally in Pendleton. In addition, we utilize the services of Oregon State Public Health Laboratory. BCHD operates under a current CLIA certificate. Laboratory services include family planning services, communicable disease services and sexually transmitted disease services.

Medical Examiner

Baker County receives medical examiner services from local physicians.

Primary Health Care

BCHD does not provide primary care services. BCHD screens clients for primary care needs and makes referrals as appropriate.

III. ACTION PLAN

Epidemiology and Control of Preventable Diseases and Disorders

Current condition – BCHD has the responsibility of reporting communicable diseases through surveillance, investigation and reporting. Routinely, BCHD operates in passive surveillance, receiving reports of disease from the medical community and laboratories. Although laboratories submit reports in a timely manner, reporting inconsistencies exist among the medical community.

Goals

- Increase communicable disease reporting from healthcare providers.
- Maintain and expand outbreak and emergency preparedness planning with community partners.

Activities

- Provide education to local providers and their staff regarding the importance and requirement of reporting communicable diseases
- Assure that local providers and staff are aware of the BCHD after hour reporting procedure (24/7 Protocol).
- Review and analyze communicable disease statistics compiled by DHS, monitoring for emerging trends.
- Provide quarterly disease occurrence updates to the medical community (January, April, July and October of each year and more frequently as needed).
- Provide education to individuals and groups on communicable disease issues. This includes press releases to newspaper on current public health issues.
- Implement the BCHD Active Surveillance Policy and Procedure as needed.

Evaluation

- Monitor the reporting source shown in the BCHD CD Log.
- Monitor for timely reporting from providers.
- Continue quality assurance activities of communicable disease reports and investigations.

Parent and Child Health Services

WIC – see attachment

Family Planning – see the 2008 Comprehensive Plan

Immunization – see attachment

Maternal and Child Health Programs

Current condition or problem – A limited access to dental care exists for children covered by the Oregon Health Plan (OHP) and those uninsured. Currently, 2 dentists are providing dental services to children on OHP. Parents with limited resources are frequently referred to areas outside of Baker County for dental care.

BCHD began providing dental varnish services to clients enrolled in Babies First and CaCoon programs. Recently, BCHD has expanded its practice and now provides this service to all children with teeth to the age of 4 years old. Clients served after the program expansion has been minimal due to lack of client awareness, lack of trained staff and lack of program promotion.

Goal

- Increase awareness of the BCHD Dental Varnish Program.
- Increase the number of children 9 months to 4 years old receiving dental varnish services at BCHD.
- Cross-train all licensed staff in an oral assessment and application of dental varnish.
- Provide parents with resources and referrals involving available dental services.

Activities

- Provide written material to clients visiting BCHD.
- Offer dental varnish to all children receiving immunizations when teeth present to 48 months of age.
- Provide training to all licensed staff regarding dental assessments and the BCHD dental varnish procedure during nursing meetings.
- Serve on advisory committees or coalitions in Baker County that pertain to dental health.
- Promote a dental home for all children and provide referral information.

Evaluation

- Dental Varnish educational material is available and accessible at BCHD.
- Monitor the number of children receiving dental varnish services at BCHD, assessing for trends.
- All licensed staff have received dental varnish training as documented in the training log

Environmental Health

Current condition or problem – Malheur County Environmental Health provides all environmental health services to Baker County. Some of these services include health inspections, licensing and review of restaurants, public pools and tourist facilities, and assistance with food borne illness disease investigations.

BCHD provides limited education regarding environmental health issues to the community. Clients requesting information are referred to Malheur County Environmental Health.

Goal

- To Increase awareness of environmental health services among BCHD staff.
- Provide resources to clients seeking services.

Activities

- Request and receive staff training provided by Malheur County Environmental Health Services.
- Provide educational materials to Baker County residents seeking information.
- Conduct an outreach activity to promote community awareness of Environmental Health Services, such as a press release.
- Include Malheur County Environmental Services in emergency preparedness activities and outreach activities.

Evaluation

- Educational materials pertaining to environmental health services are available at BCHD.
- Completion of an environmental health outreach activity.
- BCHD staff receives training in environmental health services as documented in training logs.

Health Statistics

Current Condition or problem- BCHD employs 1 registrar and 1 deputy registrar to assist as needed. BCHD receives birth and death information in electronic format and hard copy format. All birth and death certificates are processed in a timely manner. BCHD relies on program manuals as a resource. Program policies and procedures need to be developed.

Goal

- The BCHD registrar and deputy registrar will receive additional training in vital records
- Policies and Procedures will be developed and implemented.

Activities

- BCHD staff will attend training offered by DHS that pertain to birth and death certificates.
- BCHD staff will request assistance from DHS with obtaining policy templates.
- BCHD staff will develop, review and implement policies and procedures that pertain to birth and death certificates.
- BCHD will develop a quality assurance program to provide direction in implementing new systems.

Evaluation

- BCHD will train staff on policies and procedures; training will be documented in the meeting minutes.
- BCHD will assure proper implementation of policies and procedures by quality assurance activities.

Information and Referral

Current Condition or problem – BCHD provides unbiased and accurate information and referrals to clients seeking services. Information is presented through oral presentations and written materials. In addition, information and referrals may be presented in press releases; examples include West Nile Virus dead bird reporting and Baker Vector Control. BCHD receives many referrals from community partnerships regarding activities involving public health services and available community resources.

Goal

- To continue to provide accurate and updated information and referral services.
- To maintain an accurate database of resources.

Activities

- Assure that the information and referral data base remains updated on an annual basis and as changes take place.
- Assure that written information is available upon request.
- Include BCHD information and referral training at staff meetings.

Evaluation

- Documentation of review and update of information and referral data.
- Monitor that written material is available on an ongoing basis.
- Documentation of staff training in meeting minutes.

Other Issues

Tobacco rates in Baker exceed state averages. BCHD is in the process of applying for the DHS Health Promotion and Chronic Disease Prevention, Tobacco Prevention and

Education Program Grant. We are working with state officials to develop our action plan and submit for approval. [The BCHD is approved to provide a Tobacco Program to Baker County Residents. This program is now established and is conducting required activities.](#)

IV. ADDITIONAL REQUIREMENTS

1. Organizational Chart - [See the attached updated Organization Chart.](#)
2. Senate Bill 555
BCHD does not oversee the local commission on children and families. The local comprehensive plan for children aged 0-18 include youth substance abuse, adult substance abuse and the availability of positive activities for youth during nonschool hours. BCHD will provide information and referral to all clients seeking information regarding substance abuse. In addition, we will provide information to the public regarding after school activities as we receive this information. [BCHD has reviewed the Local Commission on Children and Families comprehensive plan and invited to the planning process.](#)
3. The Baker County Board of Commission serves as the Baker County Board of Health. BCHD general advisory board does not exist. However, various advisory boards exist as required by specific programs.

V. UNMET NEEDS

BCHD values competency among our staff members. We acknowledge that a well-trained staff assures that minimum standards are met, systems are implemented correctly and policies and procedures remain updated.

BCHD values the training received from the various DHS programs. In addition, we appreciate the increased regional and online training DHS has provided to rural communities. Through the process of implementing new systems and change, we have discovered that our unmet need is additional training for support staff and fiscal staff. Training that would be helpful include topics involving medical records, fiscal programs, family planning office procedures and vital records. [BCHD continues to seek training from DHS regarding fiscal topics and policy review.](#)

[Community unmet needs include access to health care. BCHD is requesting guidance from DHS regarding chronic disease management. Baker County has limited trained licensed providers to serve this population. A newly diagnosed diabetes patient may have to travel far distances to receive adequate care.](#)

[Assistance for clients applying for and utilizing the Oregon Health Plan \(OHP\). We often hear that applying for the OHP is difficult and local residents rely on BCHD for assistance with this process. These are clients in addition to Oregon Mothers Care](#)

clients. In addition, clients are limited to providers accepting the OHP. Often times these clients are unable to travel outside of Baker County to receive services from a provider due to transportation barriers.

Baker County Health Department

2009-2010 Annual Plan

Minimum Standards

VII. Minimum Standards

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

Organization

1. Yes 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.
50. Yes No Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided.
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.
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.
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.

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

Local health department Health Administrator minimum qualifications:

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

Answer the following questions:

Administrator name: Debbie Hoopes

- Does the Administrator have a Bachelor degree? Yes No
- Does the Administrator have at least 3 years experience in public health or a related field? Yes No
- Has the Administrator taken a graduate level course in biostatistics? Yes No
- Has the Administrator taken a graduate level course in epidemiology? Yes No
- Has the Administrator taken a graduate level course in environmental health? Yes No
- Has the Administrator taken a graduate level course in health services administration? Yes No
- Has the Administrator taken a graduate level course in social and behavioral sciences relevant to public health problems? Yes No

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

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

b. Yes ___ No X 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.

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

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

OR

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

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

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

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

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

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

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

Local Public Health Authority

Baker County
County

May 1, 2009
Date

Additional information regarding questions with “no” answers

Page 11, question b

The BCHD nursing supervisor does not have a baccalaureate degree. Becky Sanders will attend a distance education program fall, 2009.

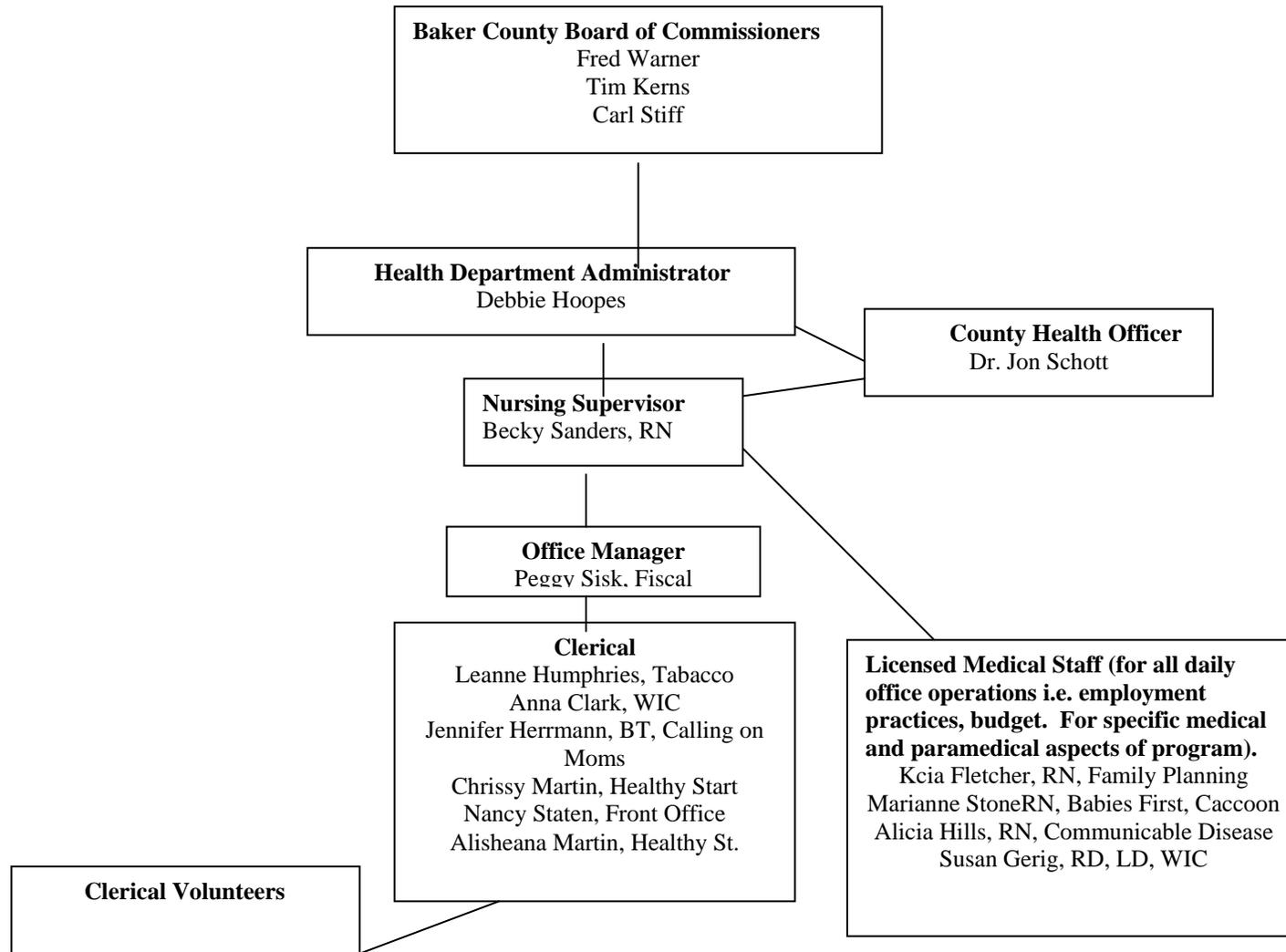
Page 10 question a

The BCHD Administrator does not have and required graduate level courses. The Administrator will pursue distance education opportunities to meet the minimum standards are required.

**Baker County Health Department
3330 Pocahontas Rd
Baker City, OR 97814
Telephone: 541 523 8211
Fax: 541 523 8242**

**Budget Contact Information:
Peggy Sisk, Office Manager**

ORGANIZATIONAL CHART



Debbie Hoopes, Administrator

Date

Revised 04/30/2009

Attachment A

FY 2009-2010 WIC Nutrition Education Plan

WIC Staff Training Plan – 7/1/2009 through 6/30/2010

Agency:

Training Supervisor(s) and Credentials:

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, 2009 – June 30, 2010. State provided in-services, trainings and meetings can be included as appropriate.

Quarter	Month	In-Service Topic	In-Service Objective
1	July 2009	Interpreting Infant Feeding Cue Identify Community Partners	Provide Anticipatory Guidance when implementing new WIC Food Pkgs To Promote Fresh Choices with high priority partners
2	October 2009	Two (or more) Participant Centered topics needing further review	To improve on those counseling skills identified by LA staff as needing further development
3	January 2010	Breastfeeding Promotion & Support	To implement the identified strategy for Bfing exclusivity & duration
4	April 2010	Two (or more) Participant Centered topics needing further review	To improve on those counseling skills identified by LA staff as needing further development

EVALUATION OF WIC NUTRITION EDUCATION PLAN
FY 2008-2009

WIC Agency: Baker County WIC

Person Completing Form: Susan Gerig, RD, LD Date: 4/23/09

Phone: 541-523-8212

Return this form, attached to email to: sara.e.sloan@state.or.us by May 1, 2009

Please use the outcome evaluation criteria to assess the activities your agencies did for each Year Two 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 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 WIC Program's Key Nutrition Messages and identify which ones they need additional training on.

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

- How were the WIC Program's Key Nutrition Messages shared with staff in your agency?
- Which messages did staff identify as needing additional training on?
- How did this training occur?

Response: (Baker County has one certifier, Susan, and two clerks, Anna, who is also training to become a certifier, and Nancy, who is WIC Clerk back-up.)

After the State-wide meeting, Susan had both WIC clerks review the key nutrition messages. (Only Susan was able to attend the State-wide meeting.) It was decided that although all of the key nutrition messages were relevant to our daily contact with clients, we would select, later in the year, topics based on the education that the State WIC staff was going to provide. (We were most interested in how Fresh Choices and the postpartum/infant food package would be marketed to support those specific key messages.) Because we were going to begin Cohort II of “Oregon WIC Listens” and because our way of communicating with the participant was going to be changing, in June 2008, I facilitated an inservice from the website, “It Starts with You!” (Although this did not address key messages, I felt it was foundational for giving the clerks an introduction to motivational interviewing.) Further training included the following:

November: Reviewed Fresh Choices status reports thus far. Anna and Susan piloted the State WIC Low Fat Milk staff inservice material from Kim McGee.

January: Decided on the three key messages of Breastfeeding package changes, Low Fat milk changes and Oral Health. This inservice included material from California re/to their breastfeeding package changes, a review of the “godmilk?” handout and lowfat milk changes in WIC and a review of the inservice on Oral Health for Pregnant Women and Infants.

February: “What is happening with postpartum mom’s and their babies starting August 2009?” was completed by Anna, Nancy and Susan.

March: “Medical Documentation” completed by Anna and Susan. (Anna currently has two more modules to complete before she’ll cert.)

Activity 2: By March 31, 2009, staff will review the proposed food package changes and:

- *Select at least three food package 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 change.*

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

- How did staff review the proposed food package changes?
- Which nutrition education messages were identified that need to be modified?
- How will these messages be shared with participants?

Response: To review the proposed food package changes, Anna and Susan were on several of the JAD calls.

As mentioned above, all three of us completed the postpartum moms and babies new food package inservice shortly after that was available from the State.

Beginning in January, Susan began telling participants about the value-vouchers coming in late summer/early fall for fresh/frozen veggies & fruits. Beginning in February, Susan offered all WIC participants a “heads-up” re/to lowfat milk. Beginning in March, Susan offered all pregnant & postpartum moms a brief message that breastfeeding will be considered the standard, enabling the baby to have what’s best and mom to benefit from a variety of veggies, fruits, whole grains, lowfat milks and extra protein foods. Once they were available, Susan used the booklet/DVD “Get Healthy Now Show” as an intro to the topic that all clients (age 7 months and older) would soon be receiving veggies & fruits as part of their monthly WIC foods.

Activity 3: Identify your agency training supervisor(s) and staff in-service dates and topics for FY 2008-2009.

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

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

Response:

Baker County WIC did conduct the in-services I identified on last year's plan. The specific inservices (listed in Activity 1) were different in content than my original plan, because with both Fresh Choices and Cohort II of Oregon WIC Listens activities happening simultaneously, our needs/interests changed as the year progressed.

Oregon WIC Listens has changed the way we do business. Although we have one certifier (Susan) and one clerk (Anna) who is working on modules and gaining experience observing certs, Anna was our "Champion" for Oregon WIC Listens. As the year progressed, we were able to include Nancy (WIC Clerk who backfills for Anna) in some of our practice sessions for Oregon WIC Listens. (We role-played in State WIC prepared skits, holding up signs when we identified a motivational interview phrase.) The area where I see the greatest change in all of us would be the Competency Area for Nutrition Ed. In the past, we tried to market the nutrition ed we wanted the participant to receive. Not only the certifier, but the clerk felt compelled to give more information than the participant was asking for. Now, we allow the participant to discover what nutrition ed they want to seek out.

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 assessment steps from the Dietary Risk Module and identify which ones they need additional training on.

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

- Did staff review the assessment steps from the Dietary Risk Module?
- Which steps did staff identify as needing additional training on?
- How did this training occur?

Response:

Just recently, Anna finished up some case studies on the Dietary Risk Module and we plan to review her questions in the next few days. Because

we were in Cohort II of Oregon WIC Listens, both Susan and Anna were able to practice and observe a different way to direct a participant through the process of a certification. Because we had regular meetings, observations and phone calls with Arienne, we have been using our critical thinking skills with the participants and reviewing our successes and challenges with the Cohort II team. Asking permission to offer Nutrition Ed, seemed to be an ongoing challenge for me. In recent weeks, I have been practicing “Connecting to Desired Outcome” as a necessary part of the ending of each cert visit.

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.

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

- How have staff modified their approach to individual counseling after completing the Nutrition Risk and Dietary Risk Modules?

Response: Before Oregon WIC Listens, I think my cert process left the client thinking, “I came, I “heard,” I went!” Now, I honestly believe the participant is identifying something they want from the visit, and in most cases, they seem to be more engaged with the process.

Goal 3: Improve the health outcomes of WIC clients and WIC 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 objective and strategy to facilitate healthy behavior change for WIC staff.

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

- Which objective and strategy did your agency select?
- How did your agency decide on this objective and strategy?
- Did the strategy help meet the objective?
- What went well and what would you do differently?

Response:

Objective was self-reporting with daily physical activity by reporting at monthly staff meetings.

I had planned to include the health department in this activity, but I didn't follow-through by alerting the entire staff to self-report.

Several employees in the health department verbalized their individual physical activity (one employee spends 4-5 mornings at the gym each week, another takes 2-3 mile walks daily in good weather. One employee, about one year postpartum, joined the local "World's Biggest Losers" program. She not only lost her "baby" weight, she began and maintained a morning routine of using her treadmill. This employee received recognition from that program, and we were all aware of her successes when cards, flowers, balloons were delivered on weeks she met/exceeded her goal.)

Although I'm a "weekend walker" around our hillside subdivision, I know I would have followed through on this goal if, early in the plan year, I had asked a friend to hold me accountable. If I had been consistent, I would have made it a priority to hold others accountable to their exercise goals.

Activity 2: Identify your objective and strategy to facilitate healthy behavior change for WIC clients.

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

- Which objective and strategy did your agency select?
- How did your agency decide on this objective and strategy?
- Did the strategy help meet your objective?
- What went well and what would you do differently?

Response:

On April 1st, The WIC Clerk contacted WIC families and asked them if they would participate in an activity about TV-Turnoff week. If they replied “yes” they were asked how many hours of screen time their family has per day and per week. They were told they would be sent a handout that included a place for them to log their screen time for a week and included ideas for enjoying physical activity and family time experiences that didn’t include screen time. Two weeks later, they were to be called back to share their results.

Number of families contacted in early April: 43.

Number of families willing to participate, who received handout in mail: 29 (Fourteen families declined, and two of those asked if by declining, they would no longer receive WIC!)

Average number of screen hours per week, when WIC clerk called participants back. (Participants had received handout, and had over seven days for logging viewing time.):

Same number of hours per week viewing time = 11 responses, average time 31.5/week.

Fewer number of hours per week viewing time = 5 responses, average time 14/week.

Increased number of hours per week viewing time = 1 response, increased 3 hrs during week logging time spent, for a total of 27 hrs that week.

We discovered there’s a lot to an effective phone survey, and I’m not certain we accomplished much with the participants’ efforts. Twelve of the families who received handouts in the mail, were unreachable for the call-back.

During the week the participants filled out their log sheets, the weather was wintry and windy. It’s encouraging that 5 of the 17 who responded to the second call, actually decreased their viewing time. (The decrease ranged from 4 hrs less to 13 hrs per week.)

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

Year 2 Objective: During plan period, in order to help improve breastfeeding outcomes for WIC participants, each local agency will select at least one objective and implement at least on strategy from the Statewide Physical Activity and Nutrition Plan 2007-2012.

Activity 1: Identify your objective and strategy to improve breastfeeding outcomes for WIC clients.

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

- Which objective and strategy did your agency select?
- How did your agency decide on this objective and strategy?
- Did the strategy help meet your objective?
- What went well and what would you do differently?

Response:

By reviewing the Breastfeeding Duration Report for the periods 7/01 – 3/30 for the past four years, I determined that we’re not meeting our objective. The following information was provided on the report, which indicated the percent of clients who had stopped exclusively breastfeeding by 6 months:

7/01/05-03/30/06	72.7%
7/01/06-03/30/07	66.7%
7/01/07-03/30/08	92.3%
7/01/08-03/30/09	100 %

The strategy was to schedule one hour per week for drop-in breastfeeding support and education, beginning this plan year. Since the objective was chosen, on WIC client days, we typically reserve 4, ½ hour appointment times for either new pregnancies or breastfeeding

follow-ups. Most days there is at least one appointment time still available close to day's end.

As in the past, I typically schedule at least one "How Will I Feed My Baby?" breastfeeding class per month.

In reviewing these (dismal) results with the WIC Clerk, we thought two things might be happening. In recent months we seem to have more participants coming onto the program late in their pregnancy and many of these participants don't indicate an interest in learning more about breastfeeding. Secondly, participants who call shortly after delivery requesting a breastpump, aren't usually requesting breastfeeding information and support. They voice disbelief that their baby needs to be at breast so often, and their responses to open-ended questions do not indicate that they plan to use any breastpump often enough to initiate/maintain good milk supply.

We will continue to have monthly classes, adjusting the times to better serve our clients, and we'll continue to invite the participant and their partner to these classes. We will continue to use each prenatal contact as an opportunity to share solutions to breastfeeding concerns each participant may be anticipating. As the breastfeeding coordinator, and main certifier, I will practice my motivational interviewing skills to better facilitate the participant's willingness to consider breastfeeding as best for Mom and Baby.

FY 2009 - 2010 WIC Nutrition Education Plan Form

County/Agency: Baker County WIC
Person Completing Form: Susan Gerig, RD, LD
Date: 4/15/09
Phone Number: 541-523-8212
Email Address: sgerig@bakercounty.org

Return this form electronically (attached to email) to: sara.e.sloan@state.or.us
by May 1, 2009
Sara Sloan, 971-673-0043

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

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

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

Resources: Food Package Assignment Module to be released summer 2009.

Implementation Plan and Timeline:

Baker County WIC staff will all complete the Food Package Assignment Module by December 31, 2009.

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

Resources: Sessions on Infant Feeding Cues at the WIC Statewide Meeting June 22-23, 2009.

Implementation Plan and Timeline:

All Baker County staff that attend the WIC Statewide Meeting (planning for all three WIC staff to attend) will receive training in basics of interpreting infant feeding cues. This training will at least be completed by December 31, 2009.

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

Example: Pregnant women will no longer be able to routinely purchase whole milk with their WIC FIs. If the nutrition education materials your agency uses indicates all pregnant women should drink whole milk, those materials would need to be revised.

Implementation Plan and Timeline:

Baker County WIC Training Supervisor will review, by August 1, 2009, all nutrition education materials our agency uses, and will revise any handouts that indicate all pregnant women should drink whole milk.

Activity 4: Identify your agency training supervisor(s) and projected staff in-service training dates and topics for FY 2009-2010. Complete and return Attachment A by May 1, 2009.

Implementation Plan and Timeline:

Completed Attachment A will be included with the rest of the 2009-2010 Baker County WIC Nutrition Plan that is due to the State WIC office by 5/1/09.

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

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

Activity 1: Each agency will identify the core components of participant centered services that are being consistently utilized by staff and which components need further developing by October 31, 2009.

Examples: Use state provided resources such as the Counseling Observation Guide to identify participant centered skills staff are using on a regular basis. Use state provided resources such as self evaluation activities done during Oregon WIC Listens onsite visits to identify skills staff are working on and want to improve on.

Implementation Plan and Timeline:

Beginning in April 2009, Anna and Susan will observe one another at least once monthly while certifying clients. Each observation period will include time to identify what's working and which skills we want to improve. Using special funding, we have plans to visit at least one other agency (Malheur Co in May) to observe OR WIC Listens and learn ways to include anticipatory guidance for Fresh Choices.

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

Examples: Using the information from Goal 2, Activity 1, schedule quarterly staff meeting time to review Oregon WIC Listens Continuing Education activities related to participant centered skills staff identified they want to improve on. Schedule time for peer to peer observations to focus on enhancing participant centered services.

Implementation Plan and Timeline:

Using State WIC provided OR WIC Listens inservices, Baker County WIC staff will include at least two OR WIC Listens quarterly inservices that address the needs of the staff that were self-identified during monthly observations. (Time will be scheduled monthly for the peer Oregon WIC Listens observations.)

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

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

- *Breastfeeding is a gift of love.*
- *Focus on fruit.*
- *Vary your veggies.*
- *Make half your grains whole.*
- *Serve low-fat milk to adults and children over the age of 2.*

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

Example: Determine which partners in your community are the highest priority to contact such as medical providers, food pantries, breastfeeding coalitions, and/or Head Start programs. Provide a staff in-service, written materials or presentation to those partners regarding Fresh Choices.

Implementation Plan and Timeline:

Baker County WIC staff will determine, by July 31, 2009, which partners in our community are the highest priority for promoting the positive changes with Fresh Choices. An in-service, written materials or presentation to those partners regarding Fresh Choices will be provided by Baker County WIC by October 31, 2009.

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

Example: Your agency is a cooperative partner in a state led evaluation of Fresh Choices such as hosting focus groups or administering questionnaires with participants.

Implementation Plan and Timeline:

Baker County WIC will partner in state led evaluations of the new food package changes such as hosting focus groups or administering questionnaires with participants.

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

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

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

Resources: State provided Oregon WIC Breastfeeding Study data, the breastfeeding promotion assessment tool and technical assistance for using the tool. Technical assistance will be provided as needed from the agency's assigned nutrition consultant and/or the state breastfeeding coordinator.

Implementation Plan and Timeline:

By December 31, 2009, Baker County WIC Breastfeeding Coordinator will contact our State WIC Nutrition Consultant and/or the State Breastfeeding Coordinator for technical assistance for using the breastfeeding promotion assessment tool to improve support for breastfeeding exclusivity and duration in our program.

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

Implementation Plan and Timeline:

Baker County WIC will implement at least one of the identified strategies (for improving breastfeeding exclusivity/duration) by April 30, 2010.

APPENDIX

Local Health Department: ~~Baker County Health Department~~
Plan A - Continuous Quality Improvement: Improving Missed Shot Rate
Fiscal Years 2008-2011

Year 1: July 2008 – June 2009				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²

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>A. Current Missed shot rate is 14%. Objective is to decreased the missed shot rate 2% each year for 3 years to total 8%.</p>	<ul style="list-style-type: none"> • Request for DHS to provide a training regarding minimum spacing. • Provide staff training regarding contraindications and vaccine spacing. • Defer shots only for true contraindications. • Focus attention to catch up schedules. • Fully screen each client. • Give every shot due. 	<ul style="list-style-type: none"> • Assess missed shot rate, determine rate. • Goal of missed shot rate 12%. • Documentation of 100% completed staff training in log. • Assess results of quality assurance activities. • Assess barriers to goal in being met if rate is not 12% or less. 	<p>The BCHD 2008 AFIX Assessment missed shot rate is --%. The Goal of 12% is not met.</p> <ul style="list-style-type: none"> • BCHD staff have completed training goals. • Each child is fully screened and every shot due is given as parent consents. • Shots are only deferred for true contraindications. 	<p>BCHD has experienced increased parents choosing not to fully immunize their children. Parents decline after receiving current evidence based information supporting vaccines. Many parents have requested alternative schedules.</p> <ul style="list-style-type: none"> • BCHD RN will provide training to the staff at EOMA (serving most children in Baker County) to help decrease barriers and support evidence based practice. • Trainings will occur during the staff meetings. • BCHD will also provide EOMA with educational materials. • BCHD will conduct trainings at the local hospital during OB staff meetings and quarterly with expecting parents addressing barriers. • BCHD will request from DHS training materials and assistance.
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Year 2: July 2009 – June 2010				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results ¹	Progress Notes ²
A. Evaluate plan, decrease missed shot rate by 2%	<ul style="list-style-type: none"> • Provide on going staff training regarding contraindications and spacing of vaccines. • Defer shots only for true contraindications. • Focus attention on catch up schedules. • Fully screen each client. • Give every shot due. 	<ul style="list-style-type: none"> • Assess missed shot rate, determine rate. • Goal of missed shot rate 10%. • Documentation of 100% completed staff training in log. • Assess results of quality assurance activities. • Assess barriers to goal in being met if rate is not 10% or less. 	To be completed for the FY 2010 Report	To be completed for the FY 2010 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 3: July 2010 – June 2011				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
A. Evaluate Plan, decrease Missed shot rate by 2%. Assess total missed shot rate.	<ul style="list-style-type: none"> • Provide staff training regarding contraindications. • Defer shots only for true Contraindications. • Focus attention on catch up schedules. • Fully screen each client. • Give every shot due. 	<ul style="list-style-type: none"> • Assess missed shot rate, determine rate. • Goal of missed shot rate 8%. • Documentation of 100% completed staff training in log. • Assess results of quality assurance activities. • Assess barriers to goal in being met if rate is not 8% or less. 	To be completed for the FY 2011 Report	To be completed for the FY 2011 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.

APPENDIX

Local Health Department: ~~Baker County Health Department~~
Plan B – Chosen Focus Area: Standards for Child and Adolescent Immunization
Practices #10
Fiscal Years 2008-2011

Year 1: July 2008 – June 2009				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
A. Increase staff knowledge of immunizations.	<ul style="list-style-type: none"> Attend trainings provided by DHS as the BCHD budget allows. Provide immunization training on a regular basis at monthly staff meetings. Assess training needs from staff. Identify training resources available, such as trainings CDC offers. Include in trainings review of current standing orders. 	<ul style="list-style-type: none"> Completion of training activities. Documentation in meeting minutes. Documentation in staff training logs. 	<ul style="list-style-type: none"> BCHD staff have increased knowledge of immunizations. Trainings have been conducted regarding barriers, eligibility, coding, contraindications, Standing orders, spacing. Documentation is completed in meeting minutes. 	<ul style="list-style-type: none"> BCHD will continue to seek current training materials and continue to conduct staff training during meetings and morning report as updates or changes occur. BCHD is committed to supporting staff development activities to assure a knowledgeable staff. BCHD will request from Oregon DHS additional training materials.

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 2009 – June 2010				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
A Increase staff knowledge of immunizations.	<ul style="list-style-type: none"> Attend trainings provided by DHS as the BCHD budget allows. Provide immunization training on a regular basis at monthly staff meetings. Assess training needs from staff. Identify training resources available, such as trainings CDC offers. Include in trainings review of current standing orders. 	<ul style="list-style-type: none"> Completion of training activities. Documentation in meeting minutes. Documentation in staff training logs. 	To be completed for the FY 2010 Report	To be completed for the FY 2010 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 3: July 2010 – June 2011				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
A. Increase staff knowledge of immunizations.	<ul style="list-style-type: none"> • Attend trainings provided by DHS as the BCHD budget allows. • Provide immunization training on a regular basis at monthly staff meetings. • Assess training needs from staff. • Identify training resources available, such as trainings CDC offers. • Include in trainings review of current standing orders. 	<ul style="list-style-type: none"> • Completion of training activities. • Documentation in meeting minutes. • Documentation in staff training logs. 	To be completed for the FY 2011 Report	To be completed for the FY 2011 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.

