

**Union County, Oregon
Local Public Health Authority Annual Plan
2011-2012**

**Center for Human Development, Inc.
2301 Cove Avenue
La Grande, OR 97850**

I. Executive Summary

Center for Human Development, Inc. (CHD), the organization responsible for providing public health services in Union County, continues our work to protect and improve the health of all county residents. There have been few significant changes in the area of public health since the submission of our Comprehensive Plan for 2008-2011. We still experience many of the same strengths and challenges that we will utilize and work to address over the next year. While there continues to be serious health concerns and economic challenges in our community, we are pleased with the work we are doing to deliver essential public health services to the community. In the past year we have continued to increase service and quality levels in all five basic services contained in statute (ORS 431.416) and rule while continuing to identify and address other needs that are unique to Union County.

CHD's priority public health goals in the next year are to continue increasing the number and scope of services we provide to Union County residents, particularly in the areas of epidemiology and control of preventable disease and disorders and parent and child health services, including family planning. We engage in ongoing community health assessment using secondary sources and by partnering with Northeast Oregon Network (NEON) and other community organizations to identify needs and develop appropriate responses.

The biggest resource available to us continues to be our highly trained and motivated staff, and our strong and active community partnerships. Our staff is extremely committed to attaining our mission of "Working for Healthy Communities" and because our resources are extremely limited they often go above and beyond to help meet the needs of those we serve. Another asset is CHD's status as a private nonprofit. This allows us to seek grants that support work beyond our state and county supported public health programs. We have had success in securing grants, but these programs are often time limited and no permanent solutions to resource issues are in sight. While grantseeking is always limited by the small amount of time our staff has to devote to this work, we will continue our efforts to raise funds in the future so to augment our ability to engage in prevention and population-based work. We also benefit from the fact that mental health and public health are housed under one roof, allowing us to provide more comprehensive services to our clients. Our new facility, which opened in February 2010, has made these services available in a better organized manner while creating new opportunities to enhance the integration of these service areas.

Our biggest challenge continues to be increasing and unmet community need, primarily due to our rural location, tenuous economic status, and lack of resources to meet significant needs. Our capacity is stretched very thin, and we cannot sustain further resource reductions without the loss of key capacities. We continue to wrestle with long term solutions to meet the resource needs for public health infrastructure in our county by seeking outside or non-traditional funding and partnerships wherever we can.

II. Assessment

Demographics and Public Health Indicators

Union County, Oregon is a rural area with a population of 25,495 people. Over half (13,085) of the County's residents live in the county's largest town, La Grande. As a result, most health care and social services are based in this community. The county's remaining residents primarily live in five smaller communities: Elgin (1,705), Imbler (295), Cove (640), Union (1,960), and North Powder (520). (Source: Portland State Population Research Center)

The unemployment picture continues to be an issue in Union County, although current numbers are similar to the state. According to the Oregon Employment Department, in January 2011 Union County had a seasonally adjusted unemployment rate of 10.5%, compared to 10.4% in Oregon. This number is up a bit from Union County's rate of 10.2% in January 2010.

Limited financial resources are also a problem for Union County residents. According to the Oregon Housing and Community Services Poverty Report 2008, the number of people in Union County with incomes less than the federal poverty level grew 18% between 2000 and 2007 and was 15% in 2008, which is higher than Oregon (13.5%) and the United States (13.2%). Union County's median household income of \$41,896 in 2008 was also lower than Oregon (\$50,165) and the United States (\$52,029). Union County's 2008 inflation-adjusted per capita income of \$22,878 was also lower than Oregon (\$26,326).

According to Children First for Oregon's Status of Oregon's Children 2010, the number of children living in poverty in Union County is 21.5%, which is 9% worse than the previous year. The number of students eligible for free and reduced lunch, another indicator of Union County resident's income, is high: the percentage of students eligible in Union County schools for 2008-2009 ranged from a low of 26% in Cove School District, to a high of 56.7% in Elgin School District.

Union County residents are uninsured at high rates—in 2005 18% were uninsured. This figure is close to that of Oregon with 19% of residents uninsured. Our total county Oregon Health Plan (OHP) eligible are about 12%, indicating that young families are hit hard by socioeconomic factors. For 2007, 47% of the births in Union County were either Medicaid/OHP (44%) or self pay/no insurance (3%). We know that underinsurance rates are a growing problem as many companies have to raise deductibles and co-pays while reducing benefits in order to continue to offer health insurance to their employees.

In addition to these socioeconomic factors, there are a number of specific public health indicators that demonstrate the issues and areas of need experienced by residents of Union County. Key health indicators are as follows.

Teen Pregnancy: Teen pregnancy is an important indicator of public health in our community, yet lack of data creates challenges in understanding the scope of this issue. The most recent final data available from the state is from 2008, when there were five *births* to teens ages 10-17. Preliminary data from 2009 indicates there were nine births to teens ages 10-17, and preliminary data for January-September 2010 shows six births to teens in the same age range. While there is

not a clear trend, it appears the number of births is not declining. The most recent final data available for teen *pregnancy* (including births and terminations) was 2007, when there were 12 pregnancies among teens ages 15-17. State data tables indicate that pregnancy data for more recent years (2008, 2009) is not available due to “Zero pregnancies reported or detailed reporting of small numbers may breach confidentiality.” Since anecdotal information indicates that teen pregnancies did occur in Union County in those years, and that the number has increased, it is most likely that this data is not available due to small numbers. Not having data available makes it difficult to evaluate trends or advocate for reproductive health education and services. (Sources: Portland State Population Research Center; Oregon Health Authority Teen Pregnancy Data)

Women In Need of Family Planning: The number of “women in need” of family planning services (women between 13 and 44 years of age, fertile, sexually active, neither intentionally pregnant or not trying to become pregnant and at an income less than 250% of federal poverty level) in Union County has been increasing at an alarming rate over the past few years. In 2010, the number of women in need was 2,648, up from 1,867 in fiscal year 2009 and up from a steady number of approximately 1,500 in previous years. While the need increased significantly, the number of females served in 2010 was 748, down slightly from 768 in fiscal year 2009 and up from 717 in fiscal year 2008. The estimated percentage of “women in need” served decreased to 28% in 2010, down from 44.3% in fiscal year 2008 to 40.2% in fiscal year 2009. There is a clear need for family planning services, and even though CHD has increased its capacity to meet this need for some reason the community is not taking advantage of these services. Source: Oregon Health Authority Family Planning Facts

Low Birthweight: The percentage of low birthweight in Union County births increased slightly in 2009 at 6.8%, up from 6.0% in 2008 and 5.4% in 2007. Preliminary data for 2010 shows this trend is continuing—the percentage of low birthweight through September 2010 was 7.5%. This rate exceeds the Healthy People 2010 goal of reducing low birthweight to an incidence of no more than 5.0 percent of live births. Source: Oregon Health Authority Birth Data.

Chronic Diseases: An examination of the age-adjusted prevalence of chronic conditions among adults in Union County compared with the prevalence in Oregon as a whole shows that our county fairs better and worse in some areas. According to the report Keeping Oregonians Healthy, age adjusted death rates for all causes, heart disease, stroke, cancer, diabetes, and tobacco related disease are lower than the state rate. The only disease that stands out is Chronic Lower Respiratory Disease, which is higher when compared with the state. Information on specific diseases are below.

Arthritis: The age-adjusted prevalence of arthritis among adults in Union County for 2004-2007 was 29.3%, compared to 26.9% in Oregon. Source: 2004-2007 BRFSS County-level Information

Asthma: The age-adjusted prevalence of asthma among adults in Union County for 2004-2007 was 10.9%, compared to 9.9% in Oregon. Data for 2002-2005 shows that the age-standardized percentage of adults in Union County with current asthma was 5th lowest in the state behind Lake, Linn, Douglas, and Josephine counties. Eighth graders

with current asthma during the same time period was 10.8% compared to Oregon at 10.2%. Asthma among children in Union County is more serious. According the Oregon Asthma Program, data from 2004-2005 shows Union County had one of the highest overall asthma control scores (indicating poor asthma control) among children ages 0-17 years on Medicaid. The average annual score for children in Union County was 2.8, the third lowest behind Clatsop and Coos counties (4.4 and 3.7 respectively). Union County had the highest asthma emergency department visits for Oregon children with asthma on Medicaid at 26.0 visits per 100 children with asthma per year. We were second among counties with the highest rates of children with low medication ratios, which indicates they have too few controller medication dispensings, too many rescue medication dispensings, or both. Among Oregon children with persistent asthma on Medicaid, 68.5 per 100 Union County children with persistent had low medication ratios. When the data was restricted to children ages 0-4 and 15-17 the results were the same. Sources: The Burden of Asthma in Oregon: 2008; Geographic Disparities in Pediatric Asthma Control among Oregon Children on Medicaid, January 2008.

Cancer: Cancer in Union County shows a mostly downward trend and with few negative variations that set it apart from other Oregon counties. Data from 2004 showed the five year trend for the County was decreasing, but breast, lung, and bronchus cancer rates increased slightly. Source: Oregon Office of Community Health and Health Planning, April 2007.

Chronic Lower Respiratory Disease: The age-adjusted prevalence of Chronic Lower Respiratory Disease was 49.1 per 100,000 for Oregon versus 52.4 per 100,000 in Union County in 2000-2004. Source: Keeping Oregonians Healthy

Coronary Heart Disease: The age-adjusted prevalence of coronary heart disease among adults in Union County for 2004-2007 was 5.1%, compared to 3.6% in Oregon. Source: 2004-2007 BRFSS County-Level Information

Diabetes: While the general trend in Oregon is for rural counties to have a higher prevalence of diabetes, Union County's rate of 4.0% is low when compared to other counties in the State and lower than the State rate of 6.6%. Source: Oregon Progress Report on Diabetes, September 2008.

Heart Disease and Stroke: Data showed that Eastern Oregon counties had the highest heart failure death rates, the lowest percentage of people who had cholesterol screening within the past 5 years, and high blood cholesterol prevalence. All of these factors play a role in heart disease and stroke risk. The age-adjusted prevalence of stroke among adults in Union County for 2004-2007 was 2.5%, compared to 2.3% in Oregon. Source: The Burden of Heart Disease and Stroke in Oregon, December 2007, 2004-2007 BRFSS County-Level Information

Overweight/Obesity: According to data from 2004-2007, the age-adjusted percentage of Union County adults classified as overweight was 42.0% compared to 36.3% in Oregon. This trend is also seen among 8th and 11th graders in the Eastern/Central Oregon region, where obesity and

overweight percentages are above that of the State by 1-2%. In 2004-2007 the percentage of Union County adults who consumed at least 5 serving of fruits and vegetables per day was 24.8% compared to 26.6% in Oregon. Among 11th graders the percent at risk of overweight was 16% for Union County compared to 13% for Oregon. Drinking soda was another notable risk factor, with the percentage that drank at least 7 sodas per week at 33% in Union County versus 27% in Oregon and the percentage who bought soda at school at least 1 day per week at 39% in Union County versus 32% in Oregon. The percentage who participated in physical education daily was also lower at 17% in Union County compared to 19% in Oregon. The percent of eighth graders at risk for overweight is 18% in Union County versus 15% in Oregon, 19% of Union County eight graders consumed at least 5 servings of fruits and vegetables per day compared to 24% in Oregon, and the percentage who bought soda at school at least 1 day per week was 24% in Union County compared to 17% in Oregon. Source: Keeping Oregonians Healthy; Oregon Overweight, Obesity, Physical Activity, and Nutrition Facts, January 2007; BRFSS.

Tobacco: The good news for Union County is that according to the Union County Tobacco Fact Sheet for 2011, cigarette smoking among adults is below Oregon (14% vs. 17%) and represents a decrease from 16% as was reported on the Tobacco Fact Sheet for 2009. Cigarette smoking among 11th graders has decreased in Union County (17% to 15%) and in Oregon (22% to 16%). Cigarette smoking among 8th graders was reported at the same as the state (9%) in 2011, but this shows an increase in smoking among eight graders when compared to 2009 data (5%). The most alarming figure related to tobacco in Union County is the percentage of adult males who use smokeless tobacco: 21% compared to 6% in the state. This number is up from 17% in 2009. The most alarming change is smokeless tobacco use among 11th graders: 2011 information indicates that 29% use smokeless tobacco. This is compared to the state at 14% and is up from 17% in 2009. Eighth grade smokeless tobacco use is also higher than the state (15% vs. 5%). Tobacco use during pregnancy continues to remain at 18%, higher than 12% in the state. Sources: Union County Tobacco Fact Sheet 2009 and 2011.

Adequacy of Local Public Health Services

Local public health services are adequate for meeting minimum requirements. CHD meets or exceeds all expected standards as evidenced by successful reviews of our programs and services. While we meet minimum standards and requirements, we do not have the resources to address the vast public health needs and issues that exist in Union County. At times we have been forced to reduce service delivery because there are simply not enough resources. Our biggest challenge is limited resources and a lack of flexibility in the resources that are available to us. For example, we have the capacity to provide an increased number of family planning services because they are reimbursement-based. Unfortunately, we do not have the resources to conduct education and outreach to let the community know these services are available so the number of people obtaining this service is on the decline. We know that the need for these services exceeds the number of people who are getting them, but we do not have the resources to get people through the door.

Extent to Which Local Health Department Assures Five Basic Services

CHD assures the five basic services contained in statute (ORS 431.416) and rule in Union County. We have a 0.50 FTE communicable disease nurse responsible for epidemiology and control of preventable diseases and disorders and a Tobacco Prevention and Education

Coordinator that also works in this area. We have 0.50 FTE immunization and family planning coordinators responsible for parent and child health services, including family planning clinics. A 1.0 FTE nurse coordinator for our home visiting programs and 2.74 FTE family advocates also assure that services are provided in this area, as does our WIC staff consisting of a 1.0 FTE coordinator and certifier, 0.75 FTE certifier, and a less than 0.25 FTE dietician. This work is supported by 1.50 FTE of nurse time to provide clinic services, along with several casual nurses used as needed. Collection and reporting of health statistics and health information and referral services are provided by all nurses and program staff. A 0.75 FTE registered environmental health specialist is responsible for all environmental health services.

Public health services are also supported by a 0.50 emergency preparedness coordinator, a less than 0.25 FTE health officer, a 0.20 FTE position for vital records, a 0.75 FTE nurse and 0.25 FTE nurse practitioner at the School-Based Health Center, and a 0.56 FTE nurse providing rural school health services.

Adequacy of Other Services of Import to Union County

This might include some of the services listed in OAR 333-014-0050 (3): Dental, Health Education and Health Promotion, Laboratory Services, Medical Examiner, Nutrition, Older Adult Health, Primary Health Care, and Shellfish Sanitation.

The number of primary health care providers available in Union County does not meet community needs. While recent data contained in the County Health Rankings report shows that the number primary care providers in Union County has increased to 115 per 100,000 Population, the number is still lower than Oregon at 133 per 100,000 Population. The majority of physicians in Union County are employed by the local hospital. There is one non-hospital physician practice in La Grande. The hospital has brought in a number of new physicians, but there continues to be unmet need. Nurse practitioners are still serving the community to help fill in the gaps. Two communities—Elgin and Union—have health clinics that provide limited health care services and one employs a physician. Most health care and social services require a trip to La Grande, which is anywhere from 15 to 20 miles away from these communities. This might not seem far, but there very limited, if any, public transportation options, and winter driving conditions can be very severe, often causing road closures between La Grande and these communities.

CHD provides dental health services through our WIC and home visiting programs and we are lucky to have an ODS dental hygiene school in our area. While we partner with them extensively to extend dental/oral health resources, the need for accessible, affordable dental health services regularly comes up as an important issue on local needs assessments.

Nutrition services are limited to WIC and home visiting programs, but are vitally needed in all programs and by the community in general. The lack is due both to resource issues and to a shortage of dieticians and nutritionists in the area.

Older adult health services, both preventative and other wise, are almost non-existent in the public health realm, with no other community programs fully closing that gap. Primary health care is very difficult to access for reasons outlined above.

III. Action Plan

A. Epidemiology and Control of Preventable Diseases and Disorders

Current Conditions and Problems

1. Current Conditions:
 - a.) We have several staff in need of CD 101 and 303 training.
 - b.) Communicable disease reporting is done in a timely manner.
 - c.) Tuberculosis has not been an issue in Union County.
 - d.) Successful tobacco prevention, education, and control efforts have been in place for three years.

2. Current Problems:
 - a.) Training for CD 101 and 303 have not been offered in eastern Oregon for some time. A CD 303 was scheduled in 2010, but since most staff did not have the prerequisite 101 they did not register for it and it was cancelled.
 - b.) Chlamydia has always been a problem in Union County, but in calendar year 2009 the number of cases rose significantly, from 44 in 2008 to 60 in 2009 and 80 in 2010. An examination of Chlamydia cases over the past 10 years shows a continual increase.
 - c.) Chronic Hepatitis C cases are steadily increasing in Union County. Three cases appeared in 2005, and in 2009 the number had climbed to 40, up from 27 in 2008.
 - d.) Investigations for communicable diseases can be hampered due to problems getting information from local physicians.

Program Goals

1. Staff up to date on trainings.
2. Lower Chlamydia rate.
 - a.) Increase awareness of sexual exposure risk among at risk populations.
 - b.) Increase condom use.
3. Increase awareness of Hepatitis C.
4. Promote Hepatitis A and B vaccine for those with chronic Hepatitis C by educating other providers.
5. Educate providers about the public health implications of communicable diseases.
6. Increase timeliness of investigation completions.

Program Activities

1. Work with state to see how we can obtain CD 101 and 303 trainings in Union County in 2011-2012.
2. Investigate cases of Chlamydia and Hepatitis C to identify patterns and use those patterns to develop and implement targeted interventions.
3. Social marketing to bar and nightclub patrons about sexual exposure.
4. Increase condom accessibility in the community.
5. Work on improving communication with local physicians.

Program Evaluation

1. All necessary staff receives CD trainings.
2. Monitor incidence of STIs, especially Chlamydia and Hepatitis C.
3. Monitor condom distribution to determine if there is an increased availability.

B. PARENT AND CHILD HEALTH SERVICES, INCLUDING FAMILY PLANNING CLINICS

Current Conditions and Problems for Home Visiting Programs, School Health and General Parent Child Health

1. Current Conditions

- a.) The Babies First!, Maternity Case Management, and CaCoon programs operated by CHD utilize an innovative approach that pairs a nurse and family advocates to provide pregnant/parenting families and their children with services that lead to improved health outcomes in our community.
- b.) CHD's family planning providers work closely with home visiting staff to link pregnant/parenting clients with services that support general parent/child health.
- c.) The School-Based Health Center at La Grande High School is continuing to provide services to Union County youth. CHD received a planning grant from the state that will allow us to opening a second Union County School-Based in Spring 2011 at Union School District.
- d.) CHD is nearing the end of its third year of the Health Network for Rural Schools Program that was previously administered by OHSU School of Nursing.

2. Current Problems

- a.) Health reform legislation includes funding for home visiting programs, but the funding will likely mean significant changes Babies First!, Maternity Case Management, and CaCoon programs. At this point there is uncertainty as to what these changes will be and how they will affect the successful service delivery model we are implementing in Union County.
- b.) State budget challenges and a new administration will likely lead to significant changes in home visiting programs. It is possible funding for home visiting will be moved to a new administrative agency at the state level, creating a great deal of uncertainty as to who will administer these programs at the local level and potentially creating changes for CHD.
- c.) Increasing number of referrals to the CaCoon program due to feeding problems and associated nutritional issues. Multiple anomalies are also causing an increased number of referrals.
- d.) The percentage of low birthweight in Union County births is showing a continual increase and exceeds Healthy People goals.
- e.) There is a long term increasing trend of women smoking during pregnancy. Union County rates high when compared to Oregon.
- f.) According to the Oregon Smile Survey 2007, school children who live outside of the Portland metropolitan area experience more tooth decay, more untreated decay, and more decay severe enough to require urgent treatment than their urban counterparts. Outside of the metropolitan area, one in 17 students needs urgent care and 70% have already had a cavity.
- g.) Women who are pregnant have an elevated risk of oral disease. Periodontal disease during pregnancy has been associated with low birth weight and pre-term deliveries and poor oral health during pregnancy increases the risk of Early Childhood Caries among offspring. Despite these dangers, less than half of

pregnant women in Oregon visit a dentist while pregnant. Less than one-third of pregnant women receive information on how to prevent tooth decay in infants.

- h.) CHD no longer has two AmeriCorp VISTA volunteers who worked on a variety of public health issues with a social marketing intervention. This loss has left a huge gap in our outreach capacity, which is likely contributing to a decrease in clients learning about and utilizing public health services.

Program Goals

1. Sustain vital public health home visiting services in Union County during a time of uncertainty and transition.
2. Decrease the number of women smoking during pregnancy.
3. Determine relevant factors for low birth weight babies in Union County.
4. Increase the percentage of low birth weight babies that meet developmental milestones.
5. Increase the number of young children with access to dental services.
6. Increase the number of visits for oral health care for pregnant women during pregnancy.
7. Have a health care presence (mental and physical health) in as many schools as possible Union County.

Program Activities

1. Work with state and local partners and internally to plan for and implement any changes related to home visiting programs.
2. Home visiting and WIC certifiers have been trained in and are applying the 5 A's intervention for clients who smoke. As a part of this effort, the TPEP coordinator has provided cessation referral information (Oregon Quit Line) for staff to give to interested clients.
3. Home visiting and WIC staff will develop and implement a social marketing plan targeted at parents of young children who smoke in order to reduce smoking rate.
4. Continue to screen and refer children with feeding/nutritional issues and multiple anomalies for appropriate interventions and services through the CaCoon and Babies First! programs.
5. Link home visiting clients with low-cost dental services for their children.
6. Home visiting program will educate, advocate, refer and monitor pregnant women for prenatal services and dental health services. A focus of our work thus far has been making sure women are obtaining the prenatal care they need and linking them with dental care.
7. CHD will continue to assume responsibility for administration of the Health Network for Rural Schools program to ensure a continuing health care presence in rural Union County schools.
8. CHD will open new School-Based Health Center in Union School District.

Program Evaluation

1. Track efforts to increase the number of pregnant women receiving prenatal care and accessing dental health services.
2. Monitor smoking rates among pregnant women.
3. Monitor prenatal and dental care access among women.

4. Monitor presence in Union County schools and progress toward increasing school-based services.

Current Conditions and Problems for Immunization Program

1. Current Conditions
 - a.) Flu activity was extremely low in the 2010-2011 season as compared to previous years.
 - b.) The number of 24-35 month olds covered with the 4:3:1:3:3:1 series was 71% in 2009, a small decrease from 73% in 2008. The numbers are positive given covered rates of 57% in 2006 and 2007.
 - c.) School exclusion requirements have been positive due to strong partnerships with local schools.
 - d.) New Immunization Information System will be rolling out this year, meaning changes for providers in our community.
 - e.) Medical providers in the community have been providing more immunizations, in part due to efforts to create active local immunization coalition. We have three new sites providing VFC vaccines and two physicians and two nurse practitioners providing vaccine services. One of these clinics is in La Grande, and two are rural clinics in Elgin and Union.
2. Current Problems
 - a.) Flu activity in the 2010-2011 season has been lower than expected.
 - b.) In 2007 tied for second lowest rate for 24-35 month olds covered with the 4:3:1:3:3:1 series. Coverage increased in 2008 and 2009, but we are still far from reaching Healthy People objectives.
 - c.) Loss of childhood immunization sites in the county, leading to lack of access due to difficulty accessing primary care/medical home for children.
 - d.) Significantly incomplete immunization records in ALERT due to lack of participation on the part of a private provider.
 - e.) Term of service for VISTA Volunteer working on increasing immunization rates has ended, significantly decreasing our capacity to conduct immunization-related outreach and education.

Program Goals

1. Continue to increase the rate of up-to-date 2 year olds, with the goal of increasing by at least 1%.
2. Increase access to immunizations by pre-school and school-age children.
3. Continue community outreach to increase knowledge regarding immunization and local rates.
4. Support effective rollout of new Immunization Information System.
5. Continue work with local medical providers to encourage maximum immunization provision.

Program Activities

1. Work with the state to facilitate provider wide AFIX meeting to review data and develop plan.

2. Immunization coordinator will work with private clinics and the state to implement action plan once developed.
3. Continue meeting with immunization coalition at least quarterly.
4. Hold quarterly coalition meetings to review and update progress on above goals.
5. Coordinate with Health Network for Rural Schools staff to hold vaccine clinics for sixth graders in rural Union County schools.
6. Hold multiple pre-school immunization clinics at all elementary schools and preschools in the county.
7. Review AFIX data and collaborate with health educator at the state to determine accuracy of data and plan outreach activities based upon gaps.
8. Work with private providers to get them internet access to ALERT. Hold in-services for private provider immunization nurses on immunization standards and practices.
9. Work with private providers and the state health educator on developing a recall and reminder system.
10. Support effective rollout of new Immunization Information System by working with regional trainer and local providers.

Program Evaluation

1. Monitor school exclusion reports for number of children excluded from kindergarten and seventh grade.
2. Monitor countywide AFIX data.
3. Keep coalition minutes in order to monitor goals, activity and progress of coalition.
4. Keep records on dates and topics for in-services with nurses.

Local Health Department: Union County Public Health
 Plan A - Continuous Quality Improvement: Increase UTD rates & Access to Immunizations
 2008-2011

Year 1: July 2008-June 2009

| Objectives | Methods / Tasks | Outcome Measure(s) | Outcome Measure(s) Results ¹ | Progress Notes ² |
|------------|-----------------|--------------------|--|-----------------------------|
|------------|-----------------|--------------------|--|-----------------------------|

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.

A. Increase Up-to-date rate (4-3-1-3-3-1 series) of 2 year olds seen at Union CHD by 1% or better every year

- Provide training and increase expectation for all staff to give all vaccines due at every visit in order to reduce missed shot rate from present 27%
- Staff review of contraindications & precautions for all vaccines to also help reduce deferral of vaccines
- Staff will enter all shot records into IRIS within the expected 14 day time frame
- Design recall/reminder process to augment IRIS postcards
- Create process to help families make next appointment before leaving clinic
- Review & revise WIC partnership to be sure patients needing shots are sent over to immunization program for vaccines
- Collaborate with Child Care Resource and Referral to provide vaccine education to the childcare providers and parents

- Training held by: [date]. Training done by: [name]
- Contraindication/precaution workshop held on: [date]. Number of staff trained: —
- Quarterly review of shot records to assess progress of simultaneous vaccine administration (giving all shots due at every visit and /or having reasonable deferral notes in chart)
- Quarterly review of IRIS to ensure data is entered correctly and within the 14 day limit
- Reminder/recall system set up by [date] and used monthly
- System to help families make next appointment set up and functioning by [date]
- System to assist WIC staff refer patients to IZ program for vaccine administration in place by [date]
- Number of visits conducted and estimated reviews completed
- OVERALL OUTCOME: UTD rate will increase by 1% or more by June 30, 2009

*Regular Contact has been made with the Regional Medical Clinic to educate staff, new and existing, on immunization practices and Union county rates. Done by Rachele Lequerica, immunization Coordinator March-April of 09'
 *The IRIS quarterly review data shows the percentage of data entered within 14 days was %59.
 *Reception staff has developed a tickler system using IRIS in order to assess past due shots and forecast next shots due.
 *WIC staff assesses their client records with each appointment and makes referrals to PH staff if the child is past due on immunizations.
 *Up-to-date rates for the Health Department for 24-35 month olds increased from 57% in 2007 to 73% in December of 2008. This is an overall increase of 16%. This was provided by the most recent AFIX data.
 *Union county Immunization coordinator has conducted 3 site visits involving immunization education, record reviews for registered children and provided written materials for parent education.

*Two site visits have been conducted to provide education and written materials to nursing staff. Regional Medical staff is working on a date for an educational class on immunizations and rates. Date TBA.
 *Written material included contraindications and precautions regarding vaccines in addition to: parent education materials, dosing schedules, minimum spacing recommendations, and vaccine follow up care. We are working on developing other training opportunities with other local health care providers. We have developed an immunization coalition that has held two meetings to date. We expect to conduct another meeting in May '09. Participants included: health care providers, community stakeholders and parents. Staffing changes have created scheduling conflicts in the recent past temporarily effecting outreach practices.
 *We believe the data reflects a low number of on time entries due to our flu clinic information. This data is transmitted electronically and was not routinely updated every 14 days. We are addressing this issue with current staff to come up with a more efficient data entry process.
 *Reception staff keeps a file with these records and does weekly-monthly phone calls and reminder cards to parents to inform them of their child's past due immunizations. This assists them in scheduling for these immunization appointments.
 *WIC staff is conscious of Union County immunization rates and understands the need for up to date vaccination practices. This will be an ongoing collaboration.
 *There is an ongoing effort to increase rates further using: reminder/recall systems, community education and outreach, and collaboration with other health care providers.

Year 1: July 2008-June 2009

| Objectives | Methods / Tasks | Outcome Measure(s) | Outcome Measure(s) Results ³ | Progress Notes ⁴ |
|--|--|--|---|---|
| <p>B. Increase access to Immunizations for pre-school and school-age children</p> <p>C. Continue community outreach to increase knowledge regarding immunizations and local rates.</p> | <ul style="list-style-type: none"> <input type="checkbox"/> Immunize all sixth graders in the county with the TDAP immunization by holding shot clinics in schools. <input type="checkbox"/> Target preschool-age children for Hepatitis A vaccines by holding multiple preschool immunization clinics at all elementary and preschools in Union County <input type="checkbox"/> Coordinate with Health Network for Rural Schools nurse and school staff to conduct clinics and keep ALERT updated. <input type="checkbox"/> Create system so Health Network for Rural Schools nurse & school staff can report all immunizations to ALERT (or to IRIS if UCHD enters the data) <input type="checkbox"/> Continue quarterly coalition meetings. <input type="checkbox"/> Continue outreach among local health care providers to provide education and training. | <ul style="list-style-type: none"> <input type="checkbox"/> Number of elementary school clinics held: __. <input type="checkbox"/> Number of children immunized: __ <input type="checkbox"/> Number of pre-school clinics held: __. <input type="checkbox"/> Number of children immunized: __ <input type="checkbox"/> Coordination meetings held with HNRS on [dates] <input type="checkbox"/> All shot records entered into IRIS or ALERT within 14 days of vaccine administration | <p>*Five clinics have been held thus far in the outlying schools by the Health Network for Rural Schools nurse. Four more clinics are scheduled to take place in May of 09'. There is an estimated 50 children that have been vaccinated with the Tdap through these clinics.</p> <p>*Six clinics have been held for preschool age children. An estimated 50 children were vaccinated through these clinics.</p> <p>*Regular monthly contact is kept with Health Network for Rural Schools nurse. Performance reviews are conducted quarterly to monitor performance. Feedback is also requested from the surrounding schools to evaluate performance and assess need within each school.</p> <p>*Following immunization clinics, VAR forms are promptly submitted to Health Department and entered into the data base. This is reflected in the previously stated quarterly review number.</p> | <p>*All clinics include local children from La Grande in addition to the children in the outlying communities of: Union, Elgin, Imbler and Cove. All located within Union county.</p> <p>*Additional clinics will be held periodically (at least quarterly) in attempt to reach all children</p> <p>*The Health Network for Rural Schools nurse collaborates with Health Department nursing staff regularly to provide adequate immunization coverage throughout Union County within the schools as well as the communities. This will be an ongoing effort to ensure children are up-to-date on their immunization status.</p> |

³ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

⁴ **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) Results⁵ | Progress Notes⁶ |
|-------------------|------------------------|---------------------------|---|-----------------------------------|
|-------------------|------------------------|---------------------------|---|-----------------------------------|

⁵ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

⁶ **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.

A. Increase Up-to-date rate (4-3-1-3-3-1 series) of 2 year olds seen at Union CHD by 1% or better every year

- Review expectation for all staff to give all vaccines due at every visit in order to reduce missed shot rate from present %
- Staff review of contraindications & precautions for all vaccines to also help reduce deferral of vaccines
- Staff will enter all shot records into IRIS within the expected 14 day time frame
- Recall/reminder process to augment IRIS postcards reviewed and modified as needed
- Continue process to help families make next appointment before leaving clinic
- Review & revise WIC partnership to be sure patients needing shots are sent over to immunization program for vaccines
- Continue collaboration with Child Care Resource and Referral

- Review held on: [date]. Review done by: [name]
- Contraindication/precaution review held on: [date]. Number of staff attending: ___
- Quarterly review of shot records to assess progress of simultaneous vaccine administration (giving all shots due at every visit and /or having reasonable deferral notes in chart)
- Quarterly review of IRIS to ensure data is entered correctly and within the 14 day limit
- Reminder/recall system used monthly
- System to help families make next functioning
- WIC partnership for referring patients to IZ program for vaccine administration continues
- Number of visits conducted and estimated reviews completed
- OVERALL OUTCOME: UTD rate will increase by 1% or more by June 30, 2010

-Efforts are made at each appointment to encourage parents to have their child receive all immunizations due at the time of the visit.

-The Alert/Iris printout is reviewed with the parent to show which immunizations are due currently, which are past due, and tentative dates for next immunizations due. This information is provided at check in, and reviewed again during the visit with the RN.

-Reception staff has training in the safety of vaccines and are capable of answering basic questions on the concerns of vaccines. The VIS is reviewed with the child's parent and a copy given to them . Reception staff will refer patients to the RN for detailed information and education as needed.

-Reception staff has a procedure in place for data entry into IRIS. This is done in an effort to comply with the 14 day time frame.

-A tickler system is currently in place to recall children who have past due immunizations. Reminder cards are mailed on a monthly basis. This is followed closely by a designated reception staff member.

-After completion of the appointment, RN will review next immunizations due and encourage parents to schedule for next immunization appointment. Each patient is given and checkout slip to present at checkout with reception staff, at this time they ask the client if they wish to schedule their next appointment.

-Continued collaboration with the WIC program takes place. WIC staff will review the imm. Records of each patient at the time of the visit. They will then refer their clients to PH for scheduling. Some WIC staff will schedule this appointment at the time of their visit with the patient.

-Union County Immunization Coordinator works closely with CCRR to provide in home record reviews, immunization education, referrals for access to resources, and dispensing of materials for parent education to be given by the caregiver as needed.

Continuous efforts are made to collaborate with stakeholders in the community to raise awareness of vaccine rates, provide education on the safety of vaccine while addressing vaccine concerns, and to provide support for access to immunization services. This is done through:

- quarterly immunization coalition meetings with physicians, nurses, school representatives, parents and vaccine advocates
- 1. July 23, 2009 The importance and safety of vaccines.
- 2. November 5th, 2009 H1N1 The disease, prevention, and vaccination.
- 3. April 14th, 2009 HPV Special Project
- quarterly nurses meetings which brings together nursing staff from all local clinics that provide vaccine services
- In home education, review of records and resource development for day care providers.
- Collaboration with local school staff to address the vaccine status of school aged children and provide parent education on the importance of vaccines. I attended Kindergarten roundup, an informational forum for parents on school exclusion and immunization law.

We plan to continue these efforts and work to create new routes of communication and education on the importance of vaccines.

Year 2: July 2009 – June 2010

| Objectives | Methods / Tasks | Outcome Measure(s) | Outcome Measure(s) Results ⁷ | Progress Notes ⁸ |
|--|---|--|--|---|
| <p>B. Increase access to Immunizations for pre-school and school-age children</p> <p>C. Continue community outreach to increase knowledge regarding immunizations and local rates.</p> | <ul style="list-style-type: none"> <input type="checkbox"/> Continue Immunizing all sixth graders in the county with the TDAP immunization and holding shot clinics in schools <input type="checkbox"/> Continue targeting preschool-age children for Hepatitis A vaccines by holding multiple preschool immunization clinics at all elementary and preschools in Union County <input type="checkbox"/> Continue coordinating with Health Network for Rural Schools nurse and school staff to conduct clinics and keep ALERT updated <input type="checkbox"/> Review and revise process for Health Network for Rural Schools nurse & school staff to report immunizations to ALERT (or to IRIS if UCHD enters the data) <input type="checkbox"/> Continue quarterly coalition meetings <input type="checkbox"/> Continue outreach among local health care providers to provide education and training | <ul style="list-style-type: none"> <input type="checkbox"/> Number of elementary school clinics held: ___. <input type="checkbox"/> Number of children immunized: ___ <input type="checkbox"/> Number of pre-school clinics held: ___. <input type="checkbox"/> Number of children immunized: ___ <input type="checkbox"/> Coordination meetings held with HNRS on [dates] <input type="checkbox"/> All shot records entered into IRIS or ALERT within 14 days of vaccine administration | <p>Elementary clinics:</p> <ul style="list-style-type: none"> -Tdap/Flu clinic September 24th, 2009 La Grande Middle School 26 Tdap, 32 flu administered -Flu clinic September 24th, 2009 La Grande high school-30 doses administered -Tdap clinic October 15th, 2009 La Grande Middle School 15 doses administered -Tdap clinic Greenwood Elementary 17 doses administered -H1N1 clinic February 3rd, 2010 Central Elementary-50 doses administered -H1N1 clinic February 4th, 2010 Island City Elementary-39 doses administered -H1N1 clinic February 10th La Grande Middle School- 30 doses administered <p>We have a rural health nurse that visits the surrounding rural schools on a weekly basis. She promotes vaccinations and administers vaccines as needed in the school system. She has conducted multiple clinics for: Tdap, H1N1, and Hep-A. These are conducted often times on a weekly basis.</p> | <p>Continuous efforts are made to be an active figure in the schools through out Union County to promote vaccination efforts and provide education on high risk diseases. We limit problems with access to care by conducting many in school clinics and offering a variety of clinic hours for community members. We currently have one nurse that circulates in the rural schools weekly and another that has a continuous presence in the local high school.</p> <p>Administration records are routinely returned to the agency within 24 hours for data entry in to IRIS. Efforts are made to comply with the 14 day data entry guidelines.</p> |

⁷ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

⁸ **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) Results⁹ | Progress Notes¹⁰ |
|-------------------|----------------------------|---------------------------|---|------------------------------------|
|-------------------|----------------------------|---------------------------|---|------------------------------------|

⁹ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

¹⁰ **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.

A. Increase Up-to-date rate (4-3-1-3-3-1 series) of 2 year olds seen at Union CHD by 1% or better every year

- Review expectation for all staff to give all vaccines due at every visit in order to reduce missed shot rate from present %
 - Staff review of contraindications & precautions for all vaccines to also help reduce deferral of vaccines
 - Staff will enter all shot records into IRIS within the expected 14 day time frame
 - Recall/reminder process to augment IRIS postcards reviewed and modified as needed
 - Continue process to help families make next appointment before leaving clinic
 - Review & revise WIC partnership to be sure patients needing shots are sent over to immunization program for vaccines
 - Continue collaboration with Child Care Resource and Referral
- Review held on: [date]. Review done by: [name]
 - Contraindication/precaution review held on: [date]. Number of staff attending: ___
 - Quarterly review of shot records to assess progress of simultaneous vaccine administration (giving all shots due at every visit and /or having reasonable deferral notes in chart)
 - Quarterly review of IRIS to ensure data is entered correctly and within the 14 day limit
 - Reminder/recall system used monthly
 - System to help families make next functioning
 - WIC partnership for referring patients to immunization program for vaccine administration continues
 - Number of visits conducted and estimated reviews completed
 - OVERALL OUTCOME: UTD rate will increase by 1% or more by June 30, 2011

1) Review of expectations addressed at least monthly in team meetings and nurses meetings. These meetings are held weekly. This is ongoing in relation to parental concerns or resistance on check in.

2) Reviews on contraindications and precautions on vaccines done quarterly. This includes all nursing staff.

3) Reception staff has a procedure in place for data entry into IRIS. This is done in an effort to comply with the 14 day time frame.

4) A tickler system is currently in place to recall children who have past due immunizations. Reminder cards are mailed on a monthly basis. This is followed closely by a designated reception staff member.

5) After completion of the appointment, RN will review next immunizations due and encourage parents to schedule for next immunization appointment. Each patient is given a checkout slip to present at checkout with reception staff, at this time they ask the client if they wish to schedule their next appointment.

6) Continued collaboration with the WIC program takes place. WIC staff will review the imm. records of each patient at the time of the visit. They will then refer their clients to PH for scheduling. Some WIC staff will schedule this appointment at the time of their visit with the patient.

7) Funding has been cut for collaboration with CCRR for ongoing in home education.

1) These meetings coordinate reception and nursing staff goals and efforts. Reception reviews all immunizations due with parents on check-in, nursing staff addresses parent concerns and provides education on immunization recommendation.

2) Explanation and discussion held among nursing staff for clarification and education. In addition, an educational information sheet is displayed in the nurse's station for quick reference. Review of screening questions done prior to every administration.

3) We are currently working to complete the necessary steps for EMR in order to minimize length of time for transfer of patient information.

5) A designated checkout area provides the opportunity for checkout staff to review the services provided and schedule the next visit prior to the patient's departure from our agency.

7) Education for child care providers now done through classes held by the Immunization Coordinator in collaboration with CCRR. Topics vary depending on needs and concerns of providers. Topics covered so far have been H1N1 and influenza, school exclusion, and immunization misinformation including parental education on vaccines. .

*Ongoing efforts are still being made to increase county immunization rates through education and collaboration with community partners.

Year 3: July 2010 – June 2011

| Objectives | Methods / Tasks | Outcome Measure(s) | Outcome Measure(s) Results¹¹ | Progress Notes¹² |
|-------------------|------------------------|---------------------------|--|------------------------------------|
|-------------------|------------------------|---------------------------|--|------------------------------------|

¹¹ **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.

¹² **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 access to Immunizations for pre-school and school-age children</p> <p>C. Continue community outreach to increase knowledge regarding immunizations and local rates.</p> | <ul style="list-style-type: none"> <input type="checkbox"/> Continue immunizing all sixth graders in the county with the TDAP immunization and holding shot clinics in schools <input type="checkbox"/> Continue targeting preschool-age children for Hepatitis A vaccines by holding multiple preschool immunization clinics at all elementary and preschools in Union County <input type="checkbox"/> Continue coordinating with Health Network for Rural Schools nurse and school staff to conduct clinics and keep ALERT updated. <input type="checkbox"/> Review and revise process for Health Network for Rural Schools nurses & school staff to report immunizations to ALERT (or to IRIS if Health Department enters the data) <input type="checkbox"/> Continue quarterly coalition meetings <input type="checkbox"/> Continue outreach among local health care providers to provide education and training | <ul style="list-style-type: none"> <input type="checkbox"/> Number of elementary school clinics held: __. <input type="checkbox"/> Number of children immunized: __ <input type="checkbox"/> Number of pre-school clinics held: __. <input type="checkbox"/> Number of children immunized: __ <input type="checkbox"/> Coordination meetings held with HNRS on [dates] <input type="checkbox"/> All shot records entered into IRIS or ALERT within 14 days of vaccine administration | <p>1) The Health Network for Rural School's enables a nurse to be present in our rural, outlying schools to provide needed services. Her efforts include vaccination of all school aged children with the necessary vaccines. She is present in the schools weekly and provides all immunizations on an as needed basis. This includes all childhood immunizations required for school as well as those recommended including influenza and H1N1.</p> <p>2) Preschool immunization clinics held on two separate occasions to provide all childhood vaccines due including Hep A. Walk-in clinics provided at the LHD and School Based Health Center for childhood vaccines. This increased in number and frequency as needed specifically around the beginning of the school year and school exclusion time.</p> <p>3) HNRS nurse has regular interaction with nursing staff. She presents to the LHD on an as needed basis to address concerns she is experiencing and to get vaccine for school clinics. Correspondence also done regularly through email and phone calls. Administration records are routinely returned to the agency within 24 hours for data entry in to IRIS. Efforts are made to comply with the 14 day data entry guidelines.</p> <p>4) Coalition meetings continue to be held within the community to promote awareness of vaccine related concerns and education. Materials are provided to nursing staff for parental education in addition to ongoing nursing education and updates in the immunization field.</p> | <p>Increase in access to vaccines provided through integration of the VFC program within outlying communities. Two providers have begun providing VFC vaccine and one other plans to coordinate with LHD for onsite VFC clinics. This serves two additional rural communities.</p> <p>1) Designated Influenza and H1N1 clinics were held amongst three outlying communities on: October 20th, 26th, 27th and 28th, and November 3rd. A total of 104 students were vaccinated. All vaccines are available weekly based on child need. This is an ongoing effort to improve immunization rates and comply with school law.</p> <p>2). Due to limited nursing staff and time multiple walk-in clinics were implemented to provide access to immunizations as an alternative to setting up clinics in the community when staff was unable to be absent from the LHD.</p> <p>3) This allows her to be present in the schools as much as possible with minimal interruption in her work. Performance reviews are conducted quarterly to monitor performance. Feedback is also requested from the surrounding schools to evaluate performance and assess need within each school.</p> <p>4) Coalition meetings held this year have addressed the following topics: HPV-disease, risks and vaccination. H1N1- transmission, symptoms and treatment Vaccine Related Concerns- misinformation and immunization updates. Representatives from local providers attend each coalition meeting. Ongoing education with local nursing staff completed through immunization updates and onsite training for new nursing staff in the community. Shadowing done at the LHD for new nursing staff to provide education and technique training.</p> |
|--|--|--|--|---|

Current Conditions and Problems Family Planning Clinics

1. Current Conditions

- a.) CHD has increased the amount and scope of family planning services available through increased nurse practitioner hours.
- b.) Continue linking youth with family planning services through the School-Based Health Center located in the county's largest high school.
- c.) Currently working to renovate and certify a new School-Based Health Center at Union School District to expand services to rural youth.
- d.) HPV vaccine is now available for eligible women and men who would not have been able to afford it previously.

2. Current Problems

- a.) Number of "Women In Need" increased to 2,648 in 2010, up from 1,557 in FY 2008 and 1,867 in 2009. Despite increasing provider availability, the percentage of Women In Need served decreased significantly in 2010 to 28%, down from 44.3% in 2009.
- b.) Official reports of teen pregnancy rates vary widely, but anecdotal data suggests increasing numbers of younger teens who are pregnant. In addition, the teen pregnancy prevention coalition has not functioned since 2003. The coalition was revived briefly in 2009-2010, but the AmeriCorps VISTA Volunteer staffing the coalition has left CHD so its activities have not continued.
- c.) Limited number of males accessing family planning services.
- d.) The scope of family planning services CHD is able to provide at the La Grande School-Based Health Center have been limited by school policy.
- e.) CHD's capacity to conduct outreach to educate community members about family planning-related issues and services has decreased significantly with the loss of an AmeriCorps VISTA Volunteer.
- f.) Limited access to vasectomy services in Union County.

Program Goals

1. Increase the number of vasectomies provided to males in Union County through Title X and CCare during FY 2012.
2. Increase WIN served to 50% or above during FY 2012.
3. Increase percentage of male family planning clients over the next year.
4. Increase the number of Union County residents vaccinated against HPV over the next year by offering vaccine to all family planning clients at contraceptive visits, pregnancy test visits, and annual exam visits.
5. Increase the number of Union County residents vaccinated against HPV over the next year by offering vaccine to all family planning clients that qualify for the 317 special HPV project.

Program Activities

1. Review and update policy/procedures for male family planning services. Include reception and nurses in this process.
2. Use script for reception staff to use with prospective male clients.

3. Consistently ask female clients during the intake if their male partners would be interested in family planning services.
4. Documentation will be done by adding HPV vaccine check box to nurse flow sheet and the client history form.
5. VIS forms and VARs will be available in each clinic room.
6. Contract with local doctor to provide vasectomy services; train staff on eligibility, service provision, etc.; and develop policies and procedures for providing this service.
7. Use volunteers and/or nursing students for program outreach.
8. Research and implement advertising campaign using materials provided by CCare.
9. Specifically advertise availability of IUDs and Implanon.
10. Improve counseling and documentation of family planning services provided in the La Grande School-Based Health Center with on-site support/training and chart reviews.
11. Continue providing classes on family planning and STI information in high school health classes.
12. Meet with CHD Alcohol and Drug counselors to discuss possibility of providing family planning and STI classes in their groups.

Program Evaluation

1. Monitor Ahlers data and the Family Planning Program data review provided by DHS.
2. Brochures/fliers and other outreach materials distributed throughout the county.
3. Male inclusion added to teen pregnancy prevention coalition work plan.
4. Policy and procedure revisions complete.
5. Forms revised and in use.
6. Evaluate vaccine administration data from IRIS and ECHO.
7. Evaluate IRIS immunization data.
8. Evaluate Title X data number of vasectomies provided.
9. Review Family Planning Program data provided by DHS.

**FAMILY PLANNING PROGRAM ANNUAL PLAN FOR
COUNTY PUBLIC HEALTH DEPARTMENT
FY 2012**

July 1, 2011 to June 30, 2012

**Agency: Union County Center for Human Development
Contact: Joelene Peasley, RN, FNP**

Goal 1: Assure continued high quality clinical family planning and related preventive health services to improve overall individual and community health.

| Problem Statement | Objective(s) | Planned Activities | Evaluation |
|---|--|---|---|
| Limited access to vasectomy services in Union County. | Increase the number of vasectomies provided to males in Union County through Title X and CCare during FY 2012. | <ul style="list-style-type: none"> *Meet with Union Family Health Center and Dr. Monte to discuss details of the service and contract, get contract signed. *Complete training with nurses and Dr. Monte on vasectomy counseling and follow-up. *Develop policy and procedure for the service. *Educate PH staff and Union Family Health staff on the referral and eligibility process. | Evaluate Title X data number of vasectomies provided. |

Goal 2: Assure ongoing access to a broad range of effective family planning methods and related preventive health services.

| Problem Statement | Objective(s) | Planned Activities | Evaluation |
|---|--|--|---|
| <p>CHD Family Planning Clinic has a decreased percentage of Women In Need (WIN) served but the county has an overall increase of WIN.</p> | <p>Increase WIN served to 50% or above during FY 2012.</p> | <ul style="list-style-type: none"> *Use volunteers and/or nursing students for program outreach. *Research and implement advertising campaign using materials provided by CCare. *Specifically advertise availability of IUDs and Implanon. *Improve counseling and documentation of FP services provided in the La Grande SBHC with on-site support/training and chart reviews. *Continue providing classes on FP and STI information in high school health classes. *Meet with CHD Alcohol and Drug counselors to discuss possibility of providing FP and STI classes in their groups. | <p>Review Family Planning Program data provided by DHS.</p> |
| | | | |

Progress on Goals / Activities for FY 2011
 (Currently in Progress)

| Goal / Objective | Progress on Activities |
|---|--|
| <p>Very low percentage of male family planning clients.</p> | <p>Policies and procedures were put in place to serve male clients in the FP program. There was a good initial start to the process until our clinic relocated into a new building and restructuring of the FP intake process occurred. We are currently retraining staff on the process for screening males for the FP Program. We did see a small increase of male services from 0.3% to 1.1% in the short time males were being screened appropriately.</p> |
| <p>Inconsistent HPV vaccine counseling and administration for FP clients.</p> | <p>We implemented screening and education for HPV vaccine in all FP visits. Intakes include screening for 317/VFC, self-pay or private insurance coverage for HPV. Documentation of HPV vaccine is recorded in each FP chart. VIS and VARs are available in each clinic room. The number of HPV vaccine doses given this year so far is 343 compared to 129 doses given last year.</p> |

C. Environmental Health

Current Conditions and Problems

1. Current Conditions:

- a) CHD's Environmental Health Program has been administered at the county level for over five years. Substantial progress has been made in stabilizing program funding.
- b) CHD's 0.75 FTE Environmental Health Specialist (EHS) became registered this year. Increased demand for services over the summer months when temporary restaurant inspections are at their peak requires up to 5 additional hours per week.
- c) Since the county assumed its operation, the local program has added the drinking water and tobacco enforcement programs.
- d) There are more than 137 licensed facilities in Union County providing eating, living, and recreational accommodations.
- e) There are more than 26 well sites in Union County monitored by Environmental Health following the guidelines of Oregon DEQ and the federal Clean Water Act.
- f) The Environmental Health Program provides an informational and enforcement role for Oregon's Tobacco Prevention and Education Program.
- g) The Environmental Health Program works in partnership with the Communicable Disease Program and the Emergency Preparedness Program to educate, investigate, and control countywide foodborne and non-foodborne outbreaks.

2. Current Problems:

- a) Work flow for the EHST is complicated by the seasonal changes in the number of temporary restaurants in need of inspection.
- b) There is a language barrier with certain food service facilities whose primary language is not English and/or who speak very little English.
- c) Culturally, some food handlers have different views of proper sanitary practices when compared to the guidelines provided by the Oregon Statute (OAR 333-150) and the 1999 FDA Food Code.
- d) There is limited awareness of local environmental health resources and issues such as air quality and asthma. Union County has a high percentage of days when the air quality is in the unhealthy range. Union County also has one of the highest childhood asthma rates in the state.

Program Goals

1. Work toward developing an ongoing solution to the seasonal shifts that impact the work flow of the EHST.
2. Explore options for expanding the scope of CHD's environmental health work to address issues such as air quality, asthma, the built environment, etc.

Program Activities

1. Conduct health inspections of all licensed facilities in a timely manner.
2. Conduct inspections of unlicensed facilities as requested by those facilities; certified day care facilities, certified day care homes, jails, and juvenile detention centers.
3. Conduct health inspections of all public schools.

4. Conduct inspections of licensed temporary restaurants.
5. Properly track all temporary restaurant facilities in Union County.
6. Track all newly issued food handler cards.
7. Maintain scheduled testing and licensing for food handlers in Union County.
8. Perform investigations prompted by citizen complaints on potential health hazards in licensed facilities.
9. Make arrangement with a person who speaks associated languages to help educate the limited English speaking food handlers in proper food handling techniques and to pass the examination for the food handler card.
10. Monitor and assure that the drinking water in Union County is safe by providing and maintaining sanitary survey inspections, regulatory assistance and training, compliance assurance, emergency response planning, investigation and response on contamination incidents.
11. Develop an air quality communication program to inform Union County residents of current air quality conditions.
12. Establish protocol for certain telephone inquiries relating to mold, radon, and other environmental health requests.
13. Provide accurate Summarizations for the 2011 Licensed Facility Statistics Report.
14. Explore options for increasing CHD's role in environmental health, especially as it relates to health indicators such as asthma that impact Union County.

Program Evaluation

1. Review data from the Phoenix database system to ensure completeness and accuracy.
2. Inspection scores of low scoring restaurants will improve.
3. Increase in food handler cards issued to individuals with English as a second language.
4. Increase in food handler cards issued to all food service workers.
5. Increased engagement in broader environmental health issues.

D. Health Statistics

Current Conditions and Problems

1. Current Conditions
 - a.) Union County Public Health currently tracks health data in the following state public health systems: vital statistics data base, CD data, ORCHIDS, IRIS and ALERT, Ahlers, EDRS, Phoenix Database System, and Fusion.
 - b.) We also collect service, demographic, clinical and billing data in a CHD system called ECHO.
 - c.) CHD reviews health statistics from various data sources compiled by the Center for Health Statistics, the State Office of Rural Health, and others.
 - d.) CHD is partway transitioned into using the EDRS.
 - e.) CHD works closely with Union County providers of childhood immunizations to encourage the entering immunization data in ALERT.
 - f.) Union County was awarded a grant from the state to develop new technology that allows for the transfer of immunization information between our Electronic Health Record and the new ALERT Immunization Information System in real time.
2. Current Problems
 - a.) While much progress has been made in the area of data entry by local immunization providers, there are always some that do not comply and constant education must occur.
 - b.) Information on health issues that are occurring locally can be challenging due to delays in data being available from the state and changes in data collection instruments (state youth surveys, census, etc.).

Program Goals

1. Enroll physicians with biometric signature for EDRS.
2. Maintain/improve ratings for timeliness and accurateness of communicable disease reporting.
3. Provide education and support related to ALERT data entry.
4. Conduct regular assessments so accurate, timely local data is available

Program Activities

1. Continue reporting data to state per various program requirements.
2. Monitor state reports for accuracy of data (monthly communicable disease reports, home visiting reports, etc.)
3. Transition fully to EDRS by having vital statistics staff person work with state on training and implementation groups.
4. Work with local physicians to enroll E-signatures.
5. Continue immunization coalition to educate local providers on the importance of immunization data collection and data entry in to ALERT system.
6. Work with partners to conduct local needs assessment activities.

Program Evaluation

1. All physicians will be enrolled with electronic signatures.
2. Monitor site review results to determine needed areas for improvement in data collection.
3. Monitor data reports, especially communicable disease reports, for accuracy of data.
4. Immunization coalition meetings held at least quarterly.
5. Local needs assessments conducted on a regular basis.

E. Information and referral

Current Conditions and Problems

1. Current Conditions
 - a.) CHD Public Health has a Web site that is updated regularly with information on each program, health information on current health issues, contact information and opportunities for public input.
 - b.) CHD is developing a presence on social networking sites like Facebook and Twitter to share more information about our work with the public.
 - c.) Nurses respond to inquiries and concerns from the public on specific issues on a case by case basis, also providing written educational material/brochures as appropriate.
 - d.) Periodically public health staff writes Community Comments in the local newspaper addressing various health topics.
 - e.) CHD staff work with the media and county staff on disseminating health information to the public in a timely and targeted manner when needed, as during H1N1, West Nile, and Pertussis outbreaks.
2. Current Problems
 - a.) Delivery of population-based prevention messages and interventions is extremely difficult due to lack of resources. We know that our ability to educate the public is limited by the revenue sources that are available to us. Our ability to serve older adults, for example, is limited to activities requiring limited resources, such as flu shots, because we do not have revenue streams targeted to this population.
 - b.) Community health system assessments reveal that more staff time is needed to push health education material to the public, especially to partner organizations with little staff to seek information for their clients.
 - c.) CHD's capacity to conduct public health outreach decreased significantly with the loss of two AmeriCorps VISTA Volunteers, which has led to extreme difficulty in the area of information and referral.

Program Goals

1. Keep community updated on current relevant public health issues.
2. Push information to segments of the community and partners serving them to increase community awareness of local issues related to underutilized services, such as childhood immunizations and family planning, and diseases like Chlamydia that are experiencing upward trends.
3. Explore possibilities for expanding the reach of our services to those groups and individuals we face challenges in serving.

Program Activities

1. Continue to keep Web site and social networking sites updated with current program and local health information.
2. Identify and have staff disseminate existing health information to relevant partners.
3. Work with the local newspaper, County staff and vector control program in disseminating timely public health information during mosquito season.

4. Explore partnerships with organizations providing services to groups who could benefit from additional services.

Program Evaluation

1. Monitor updates of Web site.
2. Monitor health articles in the paper.
3. Monitor partnership development and collaborative efforts with other organizations and groups.

F. Public Health Emergency Preparedness

Current Conditions and Problems

3. Current Conditions

- a.) Center for Human Development, Inc. (CHD) has a 0.50 FTE emergency preparedness coordinator working on emergency preparedness in our community.
- b.) The preparedness coordinator is highly trained and has been with CHD for many years, which has led to strong connections with local partners.
- c.) We have developed solid working relationships with other important community stakeholders including the Union County emergency manager and the local hospital. This includes monthly meetings between CHD, the county emergency manager, and hospital emergency response coordinator.
- d.) CHD has used real events to practice our response plans like our flu clinics and Pertussis outbreaks along with conducting additional exercises as needed.
- e.) CHD utilizes HAN and has had a high participation rate in state and regionally-initiated drills related to HAN and satellite phones.

4. Current Problems

- a.) The number of staff with training in Incident Command Structure, CD 101 and 301, HAN, and other desirable emergency preparedness relevant training is limited.
- b.) Preparedness plans are in place but many need updates. This includes the need to review existing documents and procedures related to isolation and quarantine and working with legal council to ensure they are adequate.
- c.) We have not had the opportunity to develop our plans related to serving the needs vulnerable populations and have not utilized all of the internal resources we have to do this (i.e. staff working with developmentally disabled and mentally ill clients).
- d.) The large geography and widely spread population in Union County raises concerns about our ability to dispense prophylactic medication or vaccine within 48 hours.
- e.) Testing of 24/7 response systems has not been done as often as we would like due to changes in procedures and staffing.
- f.) CHD previously served as the Regional Lead Agency for Region 9 until this function was taken back by the state. The loss of this role is likely to reduce valuable connections CHD had with local and regional partners.

Program Goals

1. CHD staff is adequately trained in appropriate areas of emergency response.
2. Plans and systems are in place and up-to-date to ensure effective respond to emergencies, including vulnerable populations and mass dispensing plans.
3. Strengthen integration of emergency preparedness, communicable disease, environmental health, and hospital preparedness to support effective response efforts.
4. Testing of 24/7 system occurs on a regular basis.

Program Activities

1. Continue participating in regular preparedness meetings and in Hospital Preparedness Program activities.
2. Develop plans for serving vulnerable populations. Engage staff working with developmentally disabled and mental health communities in this process.
3. Develop feasible mass dispensing plan.
4. Conduct testing of 24/7 response system monthly.
5. Update all existing plans and ensure that all other necessary plans are created and exercised if appropriate.

Program Evaluation

1. Completed vulnerable populations and mass dispensing plans.
2. Response system testing record.
3. Review of plans for updates and completeness.

G. Other Issues

Current Conditions and Problems

1. Current Conditions

- a.) Northeast Oregon Network (NEON), a collaboration of health care providers in Union, Baker and Wallowa counties that started at CHD is now operating under its own 501(c)(3). They are currently implementing a local health care coverage product and CHD is involved in the process.

1. Current Problems

- a.) Union County has a very high un-insurance rate and a significant number of births in Union County are in the payment category of publicly funded or charity care.
- b.) There is a lack of primary care capacity in Union County, resulting even in insured individuals not being able to access physician care.

Program Goals

1. Implement three partial solutions to local access to care issues in the next three years in partnership with NEON.

Program Activities

1. Support NEON in their efforts to increase health care access in Union County.

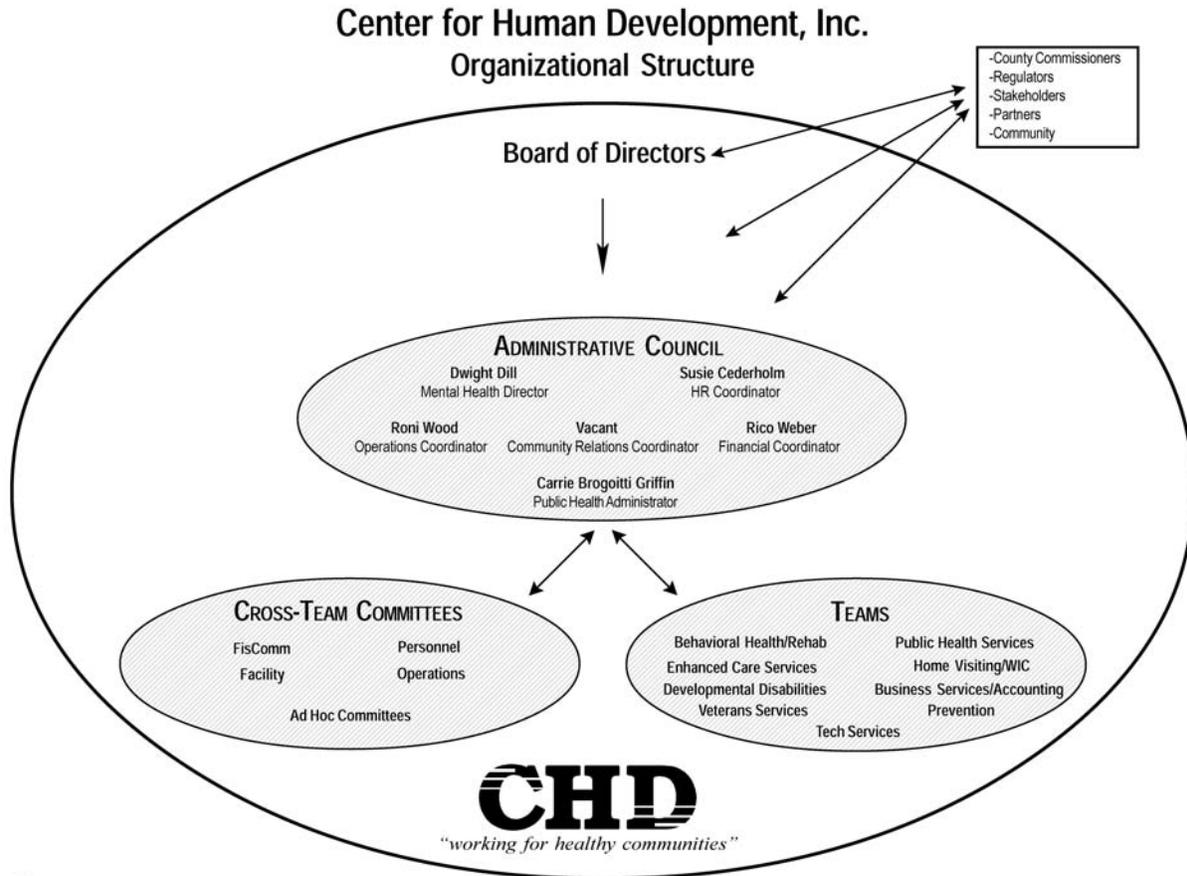
Program Evaluation

1. Monitor number of new health care access programs/products implemented.

IV. Additional Requirements

Organizational Chart

The organizational chart for Center for Human Development, Inc. is below.



4/11

Board of Health Description

Center for Human Development, Inc. (CHD) is a nonprofit corporation responsible to a Board of Directors. Union County contracts with CHD to be the Public Health Authority, so CHD's Board serves as the local Board of Health. The Board is comprised of six community members who meet monthly. A CHD staff member also serves as a representative to the Board. The Board is ultimately responsible for the agency, while delegating the executive function to CHD's Administrative Council (described below). The Board of Directors oversees the finances, assets and affairs of the organization. Included among the duties of the board are to:

The Administrative Council is responsible for the executive functions of the organization including: strategic, financial, human resources, legal, community relations, organizational structure, information, and clinical leadership. The public health administrator is a member of and accountable to this team with responsibility for the functions identified in the statutes and administrative rules.

Public Health Advisory Board

The Union County Human Services Advisory Committee is a group of community members appointed by the Union County Commissioners. The Commissioners utilize the Committee as a means of monitoring CHD's work on their behalf. The Committee provides assistance with mental health and public health programs by offering guidance and support to Center for Human Development administrators.

Senate Bill 555 CCF Coordination

The Local Public Health Authority (LPHA), CHD, is not the governing body that oversees the local Commission on Children and Families (CCF). The LPHA and the local CCF do engage in a number of coordinating activities. A member of CHD's Administrative Council currently sits on the board of the CCF. The director of the CCF regularly attends the Union County Health and Human Services Advisory Committee, the committee responsible for serving as advisors to the county commissioners on the status of public health and mental health services in the county and monitoring the county contract with the CHD. In addition, CHD staff sits on various CCF committees, and staff of both the LPHA and the CCF participates in many joint activities throughout the year.

V. Unmet Needs

CHD has identified the following areas of unmet need that we are not currently able to address, due to lack of available resources:

- **Outreach and Education:** Over the past year the number of people accessing CHD's services has been decreasing in areas where the need is increasing or unchanged, such as family planning, WIC and the School-Based Health Center. We attribute this to a lack of resources to conduct outreach and provide education about our services and about public health in general. We need dedicated resources to support outreach efforts.
- **Accreditation:** CHD is excited about the prospect of becoming an accredited public health department, but the amount of work that needs to be done is extensive. Without additional resources to focus specifically on accreditation efforts, preparing for accreditation will be a lengthy process.
- **Population-Based Prevention Efforts:** Aside from very specific and prescribed funds from the state, our organization struggles with finding resources to dedicate to "upstream" public health efforts aimed at addressing issues at the population level.
- **Environmental Health:** We have not been able to address environmental health issues beyond our water or facility inspection programs. Efforts such as addressing obesity through the built environment, addressing asthma through air quality monitoring, looking at climate change and its potential impact on our community, and/or decreasing childhood lead levels through lead education/intervention programs are not possible because we do not have the resources.
- **Access to Care:** Primary care is limited in our county due to few primary care providers, high uninsured rates, and lack of resources on the part of individuals to pay for care.
- **Chronic Disease Prevention:** Chronic diseases are of significant concern in the County, yet there are not enough chronic disease prevention or public health intervention programs.
- **Childhood Asthma:** High childhood asthma rates and poorly treated asthma are significant issues in Union County that are not being adequately addressed.
- **Older Adult Services:** There is a large older population in Union County but preventive and other general public health services that address their needs are limited.
- **Nutrition Education:** Data raises serious concerns about the nutrition of Union County residents being very poor yet there are limited services to help populations who are not involved with WIC in this area.

VI. Budget

Center for Human Development, Inc.'s most recent Financial Assistance Contract has been used to project the amount of funding we will receive from the state in 2010-2011. Projected revenue is identified in the table below.

**Center for Human Development, Inc.
Projected Revenue
2011-2012**

| Supported Program Element (PE) | Projected Award Amount Based on 2010-2011 Award |
|---|--|
| PE 01: State Support for Public Health | \$32,352 |
| PE 04: Public Health Response to H1N1 Influenza Vaccine | \$16,613 |
| PE 12: Public Health Emergency Preparedness | \$81,030 |
| PE 13: Tobacco Prevention and Education | \$56,511 |
| PE 40: Women, Infants and Children | \$151,607 |
| PE 41: Family Planning | \$19,308 |
| PE 42: MCH-Title V – Flexible Funds | \$12,203 |
| PE 42: MCH-Title V – Child and Adolescent Health | \$5,231 |
| PE 42: MCH/Perinatal Health – General Fund | \$1,841 |
| PE 42: MCH/Child and Adolescent Health – General Fund | \$3,456 |
| PE 42: Babies First | \$5,831 |
| PE 43: Immunization Special Payments | \$11,666 |
| PE 44: School Based Health Centers | \$82,000 |

A copy of the Local Public Health Authority public health budget can be obtained using the following contact information.

Rico Weber
Fiscal Coordinator
Center for Human Development, Inc.
2301 Cove Avenue
La Grande, OR 97850
541-962-8877
www.chdinc.org

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.
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 (Not Applicable)
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: Carrie Brogoitti Griffin, MPH

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

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

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

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

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

AND

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

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.

Center for Human Development, Inc.
Local Public Health Authority

Union
County

May 1, 2011
Date

Appendix E

EVALUATION OF WIC NUTRITION EDUCATION PLAN FY 2010-2011

WIC Agency: Union County

Person Completing Form: Patty Rudd / Linda Buckingham

Date: March 31, 2011 Phone: 541-962-8829

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

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

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

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

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

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

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

Response:

Training supervisor completed online Participant Centered Education module August 31, 2010.

The Participant Centered Education Module was completed and passed by Patty Rudd and Linda Buckingham and the dates were entered into TWIST prior to July 31, 2010.

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

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

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

Response:

The Home visiting staff attended the Oregon WIC Listens Training in 2008-2009 and passed the posttest of the Participant Centered Education e-learning modules prior to December 31, 2010. Dates were entered into TWIST.

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

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

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

Response:

Patty Rudd and Linda Buckingham attended the 2010 Fall Regional Group Participant Centered Education held in Baker City.

We have not used the information received in that training yet. We currently have not set up any group classes.

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

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

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

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

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

Response:

We do a good job of Breast Feeding promotion and support for our clients but feel that we need to offer a Breast Feeding class for our participants.

We developed a Breastfeeding packet called “Thanks for giving your baby a great start” for Mom’s to be. This packet includes a Birth card to include in their birthing plan, brochures such as It’s my birthday ~ give me a hug, Making Milk, Secrets of baby behavior and Discharge Instructions. We wanted to give our clients some tangible information to take with them to the hospital at a time when they might not remember everything they wanted for their birthing experience.

This strategy was developed in September 2010.

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

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

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

Year 1 Objective: During planning period, each agency will identify organizations in their community that serve WIC participants and develop strategies to strengthen partnerships with these organizations by offering opportunities for nutrition and/or breastfeeding education.

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

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

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

Response:

We invited Marilyn Herbst with Head Start to attend the Group PCE Fall training. She had planned to attend but was not able to attend because of an unexpected conflict.

We have a great partnership with Head Start and hope to further enhance that relationship in the future.

Patty spoke to the IBCLC Pediatric Nurse at our local Children's Clinic about being an additional resource for our breastfeeding mother's who might need help with problems beyond our scope of practice. She has graciously agreed to help as needed.

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

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

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

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

We choose to invite Chelsie Evans, the nursing coordinator for the Babies' First, MCM and Cacoon Home visiting program. We work closely with her as most of her clients are currently on WIC.

Our program goals are similar and we can help each other reinforce the participant centered education. Both programs promote Breast feeding and healthy choices.

We received very positive response from Chelsie Evans RN, and she is willing to complete the training when available.

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

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

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

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

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

Response:

Patty Rudd and Linda Buckingham have completed the new online Child Nutrition Module and the Home Visiting Certifiers completed the module by June 30, 2011.

Completion date has not been entered into TWIST because it is not available to document online.

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

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

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

FY 2010-2011 WIC Staff In-services

| In-Service Topic and Method of Training | Core Competencies Addressed | Desired Outcome |
|---|---|--|
| July 27, 2010 2010 Risk Criteria Update | All core categories are addressed | For staff to understand the updated risk criteria information for Nutrition and Diet Including Vitamin D |
| September 13, 2010 Evidenced Based Breastfeeding Practices | Breastfeeding Support and Community Awareness. Attended by Linda Buckingham | Knowledge of Evidenced Based Breastfeeding Practices |
| October 12, 2010 PCE Group Training in Baker City | All core areas because it is used in any group setting for education | Goal is to learn skills for Group PCE education. |
| Iodine in-service November 29, 2010 | Pregnant and Breastfeeding women | Update staff on new information about the need for Iodine in the diet of pregnant and breastfeeding women. |
| December 2010 PCE learning modules & Posttest | All core categories | Objective was to review of the core components of Oregon WIC Listens before we move to Group PCE |
| December 2010 Supporting Breastfeeding through Oregon WIC Listens Survey | Breastfeeding Women | To assess strengths and weaknesses to plan for future efforts. |
| March 2011 Online Child Nutrition Module | Children | Increase understanding of factors influencing health outcomes of children |
| March 29, 2011 Spring PCE Group Training | All core categories | Focusing on Content and design of group PCE to continue to develop knowledge and skills |

| | | |
|---|----------------------------|--|
| <p>April 4, 2011 In-service on 2nd Nutritional Education</p> | <p>All core categories</p> | <p>Desired outcome is to help staff understand the correct documentation for 2nd NE</p> |
| <p>May 1-4, 2011 NWA Conference</p> | <p>All core categories</p> | <p>Opportunity for local staff to experience a National meeting and hear nationally recognized speakers.</p> |

FY 2011 - 2012 WIC Nutrition Education Plan Form

County/Agency: Union County
Person Completing Form: Patty Rudd and Linda Buckingham
Date: March 22, 2011
Phone Number: 541-962-8829
Email Address: prudd@chdinc.org

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

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

Year 2 Objective: During planning period, staff will incorporate participant centered education skills and strategies into group settings.

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

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

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

Patty Rudd and Linda Buckingham will attend the regional training to be held in Baker City for fall of 2011 focusing on content design for Group Participant Centered Education

Regional training will be held in October 2011.

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

Implementation Plan and Timeline:

We will incorporate skills and strategies from the PCE Group trainings held in the fall of 2010 and spring of 2011 to modify 1 Breastfeeding education group lesson plan, as we currently do not offer group classes. Most of our nutrition education is done on an individual basis.

Modifications to Group Lesson Plan will be completed by March 31, 2012.

An in-service for local staff will be scheduled to include PCE skills and strategies from the PCE Group training held in fall and spring.

In-service will be the regional training in October 2011..

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

Implementation Plan and Timeline:

An in-service will be scheduled for local staff to familiarize all staff with the

content and design of 2nd Nutrition Education options available to participants.

We will present this in-service using the skills learned from PCE group training.

We plan to familiarize staff with the content, target audience and the goal of the group we will offer. We will use the resource cards at the staff meeting to help us identify the learning environment and the type of materials we would like to use in our group as a team.

One strategy for staff to continue to incorporate the skills learned will be to have our home visitors invite the participants they see in the home to attend our group with the home visitor. That ensures the staff can be observed by peers and that their clients will feel more comfortable attending groups.

The goal is to help staff effectively market groups to participants.

In-service date TBD

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

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

Activity 1: Each agency will modify at least one prenatal breastfeeding class to include PCE skills and strategies by March 31, 2012. Specific PCE skills and strategies

were presented during the PCE Groups trainings held fall 2010 and spring 2011.

Implementation Plan and Timeline:

At least one prenatal breastfeeding class will be modified using the PCE skills and strategies learned in the fall and spring training by March 31, 2012.

Note: We also have contacted the IBCLC at the children's clinic who has agreed to work in partnership with us to help our clients experiencing any problems with breastfeeding.

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

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

Implementation Plan and Timeline:

An in-service will be presented to local staff by our agency's Breastfeeding coordinator and Training supervisor for breastfeeding counseling. We will include concepts from Biological Nurturing,, Breastfeeding Basics and look forward to including the support resource materials developed by the state WIC staff.

In-service will be provided to staff by October 31, 2011

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

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

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

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

Implementation Plan and Timeline:

Because Head Start shares a large part of the same population as WIC, we choose to invite Marilyn Herbst, Head Start Coordinator in La Grande, to attend the Group Participant Centered Education training. We believe there is a great opportunity to strengthen nutrition and breastfeeding education through our partnership with possible combined groups and shared information.

Date to be determined by the training logistics and registration information sent out by the state.

Activity 2: Each agency will invite at least one community partner that provides breastfeeding education to WIC participants to attend a Breastfeeding Basics – Grow and Glow

Training complete the Oregon WIC Breastfeeding Module and/or complete the new online Oregon WIC Breastfeeding Course.

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

Implementation Plan and Timeline:

We have invited Chelsie Evans, Babies First and MCM Coordinator to attend a Breastfeeding Basics Grow and Glow training or complete the online training when available. She works closely with WIC and is housed here at Center for Human Development, Inc. We share the same clients and operate with the same goals to better educate our clients in nutrition and breastfeeding for a healthy outcome. Chelsie is also available for breastfeeding support for our clients.

Date and time will be determined when the Breastfeeding course is available.

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

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

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

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

Implementation Plan and Timeline:

We will include an in-service for Factor's Influencing Health Outcomes for all certifying staff as a part of quarterly staff development plan.

In-service to be completed by March 31, 2012

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

Implementation Plan and Timeline:

All certifying staff will have completed the new online Postpartum Nutrition course by March 31, 2012 and documented in TWIST.

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

Agency Training Supervisor(s):

Training Supervisor for Union County is Jean Farmer, RD

See Attachment A

Attachment A
FY 2011-2012 WIC Nutrition Education Plan
WIC Staff Training Plan – 7/1/2011 through 6/30/2012

Agency:

Training Supervisor(s) and Credentials:

Staff Development Planned

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

| Quarter | Month | In-Service Topic | In-Service Objective |
|----------------|------------------------------|---|---|
| 1 | TBD | 2 nd Nutrition Education Options | The goal is to familiarize all staff with the content and design of 2 nd Nutrition Education options in order to assist participants in selecting the nutrition education experience that would best meet their needs. |
| 2 | TBD – July, Aug or Sept 2011 | Skills and Strategies for Regional PCE Group training | Objective is to share knowledge learned at Group PCE training of content design for Group PCE Education |
| 3 | March 31, 2012 | Factors Influencing Health Outcomes | The objective is to increase staff's understanding of the factors influencing health outcomes in order to provide quality nutrition education. |
| 4 | TBD-Jan or Feb 2012 | PCE Skills for Breastfeeding Support | In-service for local staff to present the concepts from Biological Nurturing, Breastfeeding Basics and support resource materials developed by the state WIC staff to provide breastfeeding support. |

Union County HV/ WIC 2010-2011

Completed Events:

- Taste of WIC for staff and clients (Monster Smoothie's) July 27, 2010
- World Breastfeeding Celebration August 4, 2010
- Taste of WIC (Iron rich snacks) February 26, 2011
- NWA Conference- Portland May 1st-4th, 2011

Completed In-services:

- 2010 Risk- Vitamin D July 27, 2010
- Moving Communities Toward Evidence-Based BF Practices September 13, 2010
- Fall PCE Group Training- Baker October 12, 2010
- Iodine In-service November 29, 2010

- PCE E-Learning modules Posttest (All Staff) December 2010
- Supporting Breastfeeding through Oregon WIC Listens Survey December 2010
- Online Child Nutrition Module education March 31, 2011
- Spring PCE Group Training- Baker March 29, 2011
- 2nd Nutrition Education April 4, 2011
- NWA Conference May 2011

Out Reach:

- ECPT (Early Childhood Planning Team) Every 3rd Wed. Monthly, 10
- Community Resources in Action Annually
- Ongoing Migrant Outreach (Melanie Yeates) 2011
- CHD Reader Board(WIC Builds Healthy Family's) July 2010
- Department of Veterans Affairs July 2010
- CHD Human Resource Coordinator (Workforce Development) July 2010
- Oregon State Employment Office July 2010
- Advertisement in Local Movie Theatre ?
- Brochures in the Public Library July 2010
- Brochures in Laundromats July 2010
- Hanging Poster and Brochures for WIC Info. July 2010
(Wal-Mart, Rite Aid, Albertson's, Shelter from the Storm, Veteran's Memorial Pool and Mt. Emily Safe center)
- Farmer's Market (3 Saturday's) July and August 2010
- Operation Enduring Support August 28, 2010
- Celebrate La Grande Booth September 9, 2010
- Nutritional Evaluations to Union Co. Head start September 2010

- GRH Community Health Fair April 23, 2011
- Blue Monday April 25, 2011
- Annual Reports to community partners May 2011
- Annual Reports to Physicians May 2011