

**Union County, Oregon
Local Public Health Authority Annual Plan
2010-2011**



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

I. Executive Summary

Union County has experienced few significant changes in the area of public health since the submission of our Comprehensive Plan for 2008-2011. Center for Human Development, Inc. (CHD), the organization responsible for public health services in the county, still has many of the same strengths and challenges we will utilize and work to address over the next year. While we continue to observe serious health concerns in our community and serious economic challenges due to a high unemployment rate, we are pleased at the work we are doing to deliver essential public health services to our community. In the past year we have continued to increase service and quality levels in the area of environmental health. Our capacity to manage public health emergencies also increased with the emergence of H1N1 influenza that we successfully managed with our partners utilizing an Incident Command Structure.

The priority goals for public health in the coming year are to continue increasing our low childhood immunization rate, addressing access to care issues, and providing essential services in our community along with our partners. We engage in ongoing community health assessment processes with Northeast Oregon Network (NEON) and other community partners. Reactivating a teen pregnancy coalition, providing food handler education in primary language to English-as-a-second-language employees, and increasing preventative oral health interventions to young children are among our future goals.

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, enhancing our ability to provide prevention messages to the community and promote regional networks among community service providers. These programs are often time limited, however, 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 we can 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 community need, primarily due to our rural location, declining economic status, and lack of resources to meet significant needs. Our capacity is stretched very thin, and we cannot sustain further resource reduction 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

Center for Human Development, Inc. (CHD) continues to face many of the challenges described in our 2008-2011 Comprehensive Public Health Authority Annual Plan. We have made some strides in improving the health of our community while identifying new challenges since the plan was completed. Some of the issues that continue to be relevant to the local health/public health environment include:

Primary Care Providers: 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 the county are still hospital employees, with one non-hospital practice and one doctor recently become employed by one of Union County's two community-based clinics. 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.

Unemployment: The unemployment picture has improved in Union County over the last year. According to the Oregon Employment Department, Union County had a seasonally adjusted unemployment rate of 11.4% in February 2009, which was higher than Oregon's rate of 10.6%. In February 2010 Union County's unemployment rate showed improvement at 8.9% and was lower than Oregon's rate of 10.5%. Despite the decrease in unemployment, unemployment benefit payments are increasing: in Union County the Oregon Employment Department made 1,210 unemployment benefit payments in November 2007, 2,013 payments in November 2008, and 4,077 payments in November 2009. Between February 2009 and February 2010, the number of nonfarm jobs increased by 140. The change can likely be attributed to the reopening of recreational vehicle manufacturing plants that were forced to close in early 2009 due to the economic downturn. These changes are positive news for Union County's economy, but our unemployment rate is still quite high and many of the jobs added over the past year are not living wage jobs that do not offer health insurance benefits. Because of this, CHD still plays a critical role in providing health care and mental health services to those with limited resources.

Income: Limited financial resources continue to be a problem for our county's 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). The number of children living in poverty in Union County is 20% compared to 17% in Oregon. 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.

Insurance: In 2005 18% of Union County residents were uninsured. This figure is close to that of Oregon with 19% of residents uninsured. Our total county OHP eligible are about 12%, indicating that young families are hit hard by socioeconomic status. 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.

OHSU School of Nursing: A few years have passed since Oregon Health Sciences University (OHSU) School of Nursing based at Eastern Oregon University (EOU) in La Grande began altering its role in the community. Nursing student instruction is still available at EOU, but the multiple community services OHSU provided in the past have been transitioned to local entities for over a year. Head Start, rural health clinics in Elgin and Union, jail health services, and health services in rural schools, which OHSU currently operated, are being continued by a combination of nonprofit organizations and private contractors. CHD helped fill the gap in services by temporarily providing jail health services and we continue to operate the Health Network for Rural Schools program, placing a continued strain on organizational resources. We supported the towns of Elgin and Union in their efforts to successfully create health districts and raise funds to keep their health clinics open. We have some concerns that OHSU’s gradual withdraw from participation in these community-based services will eventually lead to the discontinuation of nursing instruction at EOU, which would have serious consequences for health care service delivery in our area. In addition to having many EOU nursing students rotate through our organization for training, all of our current nurses are OHSU graduates and originally from Eastern Oregon. Removal of this resource will eventually create a huge capacity issue for nursing not just in Union County, but in all of Eastern Oregon.

Health Indicator Data: Available data tells us that the following health indicators, many of which were contained in our 2008-2011 comprehensive assessment, remain a significant concern to Union County residents.

- **Chronic Diseases:** The leading causes of death are in order Heart Disease, Cancer, and Chronic Lower Respiratory Disease based on the most recent data from 2006. These causes maintain the same rankings when looking at five year aggregated data. The percentage of adults in our county who had modifiable risk factors for chronic disease from 2004-2007 is higher than Oregon as a whole: the age-adjusted percentage of Union County adults classified as overweight was 42.0% compared to 36.3% in Oregon and the percentage of adults who consumed at least 5 serving of fruits and vegetables per day was 24.8% compared to 26.6% in Oregon.
- **Teen Pregnancy:** Based on an analysis of data available to CHD and the anecdotal information we are hearing, teen pregnancy has reached epidemic proportions in Union County. While teen pregnancy reports in available statistics are not usually high, as can be seen in the table below from 2005 to 2007 there is an upward trend.

Oregon Pregnancy Rates for Teens in Union County, 2005-2007

	Ages 10-17	Ages 15-17
2005	5.8	12.1
2006	8.8	21.2
2007	9	21.5

Note: All rates per 1,000 females

Preliminary and year-to-date data shows that the number of teen pregnancies nearly doubled from 5 pregnancies in 2008 to 9 in 2009 among teens aged 10-17. This trend indicates this is still an issue among teens in our community. We continue to hear anecdotally that the number of teen pregnancies is extremely high and it is likely the teen pregnancy rate among young women in Union County is continuing to increase.

While teen pregnancy rates are climbing, the amount of family planning services provided at CHD is decreasing. In fiscal year 2009, the number of women in need of family planning services in our county increased to 1,867, up from a steady number of approximately 1,500 each year. The number of females served did increase in fiscal year 2009, going from 717 in fiscal year 2008 to 768. However, the estimated percentage of “women in need” served decreased from 44.3% in fiscal year 2008 to 40.2% in fiscal year 2009. The previous three years showed a downward trend in total clients served that has continued in 2009: we served 1,221 in 2005 and 1,173 in 2006 to 867 in 2007. This is puzzling because we expect the rate of uninsured in our community is rising given the extremely high unemployment rate and general lack of health care resources.

Clearly there is a correlation between teen pregnancy and family planning utilization, and CHD and the community needs to take swift action to address these issues that have multiple impacts for young people, the social service system, and the entire community.

- **Tobacco Use:** The good news for Union County is that cigarette smoking among adults is below that of Oregon (16% vs. 19%). Youth tobacco use among 8th graders is also lower than Oregon (9% vs. 5%) but cigarette smoking among 11th graders is unfortunately higher (17% vs. 22%). The most alarming figure related to tobacco in Union County is the percentage of adult males who use smokeless tobacco: 17% compared to 6% in the state. Additionally, 11th graders also used smokeless tobacco at a higher percentage than the state (12% vs. 17%).

Negative trends in the number of pregnant women who smoke continue. According to the 2009 Union County Tobacco Fact Sheet, 18% of Union County infants were born to mothers who used tobacco during pregnancy in 2007, which is high compared to 12% in the state and a benchmark of 9%.

- **Prenatal care:** The percentage of women accessing prenatal care in Union County is decreasing. Preliminary data from 2009 shows that 9.2% of births did not have adequate prenatal care. This is an increase from 6.4% in 2008 and 4.6% in 2007. This is also higher than the state at 6.1% in 2009. There is also a decrease in the percentage of infants whose mothers received early prenatal care (first trimester). Preliminary data for 2009 indicates that 42.0% of mothers did not have prenatal care in the first trimester. This is a significant jump from previous years—29.1% in 2008, 23.6% in 2006 and 2007—and is much higher than the state at 28.4% in 2009. This is well below the Healthy People 2010 goal for infants whose mothers received early prenatal care of 90%.

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. 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. Because we know women who smoke when pregnant have a far higher incidence of low birthweight babies, the fact that 18% of pregnant women smoke in our county contributes to these percentages.

One positive development for prenatal care access is the fact that our hospital recently added two new OBGYN doctors, increasing local capacity to address women's prenatal needs.

- **Immunizations:** Historically Union County's immunization rates have been low. Fortunately we have made significant progress over the past few years. The percentage of 24-38 month olds up-to-date on the 4:3:1:3:3:1 series was 73% in 2008, up from 57% in both 2006 and 2007. This is exciting progress, but we are still well below the Healthy People 2010 goal of 90% coverage.

Because our childhood immunization rates have been low, most of our energy has been focused there and we have not spent much time promoting adult immunization beyond flu vaccines. The H1N1 influenza was our most significant adult vaccination effort. There is a need to increase Hepatitis A and B vaccination, particularly among the increasing number of Union County residents with chronic Hepatitis C.

- **Asthma:** According to data available between 2004 and 2007, the prevalence of asthma among adults in Union County is 10.9%, which is better than the statewide prevalence of 9.9%. Asthma among children in Union County is more serious. According to a report by the Oregon Asthma Program containing data from 2004-2005, Union County had one of the highest overall asthma control scores (indicating poor asthma control) among children ages 0-17 years that were on Medicaid. The average annual score for children in Union County was 2.8, which was the third lowest behind Clatsop and Coos counties (4.4 and 3.7 respectively). Union was the county that 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. Union County was 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.
- **Overweight/Obesity:** The percentage of adults who were overweight or obese in the Eastern/Central Oregon region in 2005 was 36.9% and 24.6% respectively, which was above the statewide figures of 35.9% and 23.8%. Union County specific data for 2004-2007 shows the percent of overweight adults was 42%, which is nearly 6 points above Oregon's 36.3%. While the difference is not extreme, the figures are still cause for consideration. This trend is also seen among 8th and 11th graders in the Eastern/Central Oregon region, where obesity and overweight percentages range over that of the state by 1-2%. The percentage of adults who consumed 5 or More Servings of Fruits and Vegetables a Day in 2005 in the Eastern/Central Oregon region was lowest in the state at 22.6%, and lower than the state at

25.9%. The percentage of 8th graders who consumed 5 or more servings of fruits and vegetables a day in the Eastern/Central Oregon region was also the lowest in the state at 20%.

- **Oral Disease:** Oral disease in children, while significant throughout the entire state, presents a higher burden to rural areas. 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. Children without insurance and from lower income families have an even greater rate of oral disease. Both of those risk factors are significantly higher in Union County.

Women who are pregnant also have an elevated risk of oral disease. However, despite the dangers of oral disease, 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.

CHD provides services in all five of the basic public health service areas. We have a 0.50 FTE communicable disease nurse responsible for communicable disease investigation and control. We have 0.50 FTE immunization and family planning coordinators. In addition to the communicable disease and immunization/family planning coordinators, we have 1.50 FTE of nurse time to provide clinic services, and several casual nurses used as needed. We have a 1.0 FTE nurse coordinator for our home visiting programs, and 2.74 FTE of family advocate staff providing services in the home. WIC has a 1.0 FTE coordinator and certifier, 0.75 FTE certifier, and a less than 0.25 FTE dietician. We have a 0.50 emergency preparedness coordinator. Our health officer is a less than 0.25 FTE, and our environmental health staff is a 0.75 FTE. Health information and referral services are provided by all nurses and program staff. We have a 0.20 FTE position for vital records. We also have a 0.75 FTE nurse in a school based health center. We have a 0.56 FTE nurse providing rural school health services.

Our staffing capacity is as low as it can go in most areas without losing program capacity. At times we have been forced to reduce the number of hours our nurses devote to clinical service delivery because of lack of revenue and use them in resource-rich areas such as emergency preparedness. Program coordination functions are provided, but these are often the functions that suffer due to very low staffing capacity. Dental health services are provided through WIC and home visiting programs. We are lucky to have an ODS dental hygiene school in our area, and partner with them extensively to extend dental/oral health resources. The medical examiner position is often unfilled and vacant due to a shortage of physicians willing to fill the role. 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 dietitians 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.

Union County is seeing improving trends in several important areas. We continue to see a slow but steady decline in our child abuse and neglect rate—in 2009 it dropped to 10.4% from 15.2% in the previous year. Child care availability remains fairly steady. We experience little to no HIV or TB incidence.

We are excited by the work being done to address access to care in northeast Oregon through Northeast Oregon Network (NEON). NEON is a collaboration of public health/mental health, social services, and medical care providers formed to address local access to care issues in Union, Baker, and Wallowa counties. We are proud that NEON has been able to reinstitute Covering Kids and Families, one of the programs OHSU stopped providing, and the program's workers in Union, Baker, and Wallowa counties are providing vital service to the community by providing education, outreach, and enrollment in programs that help them obtain needed services. NEON became its own nonprofit in 2009 and is working on a number of exciting projects. This includes developing a local health coverage product designed to meet the needs of small business owners and employees and undertaking a planning process to explore the formation of a networked tri-county Federally Qualified Health Center.

CHD was awarded a grant to host two AmeriCorp VISTA volunteers. Initially we thought the grant would be for three years, but funding ended after year two. This will be a significant loss to our health department—the volunteers were focusing on social marketing and health education/outreach programs in the areas of behavioral and public health. The resources we have for informing and educating the public are limited, making the social marketing work these volunteers conducted extremely valuable. One of their focus areas is raising childhood immunization rates, which is a serious issue in our county. The downside to this support is that it is limited in duration and ended sooner than anticipated, so we are working to identify ways to continue this work in the future.

CHD is pleased to report that we have relocated to a new facility. Our previous facility posed multiple challenges, the most significant being lack of compliance with records and ADA laws. The new facility has addressed these issues and allows our clients to obtain services in a more efficient, welcoming space.

III. ACTION PLAN

A. EPIDEMIOLOGY AND CONTROL OF PREVENTABLE DISEASES AND DISORDERS

Current Conditions and Problems

1. Current Conditions:
 - a.) We have several new staff in need of CD 101 and 303 training.
 - b.) Communicable disease reporting is done in a timely manner.
2. Current Problems:
 - a.) 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. An examination of Chlamydia cases over the past 10 years shows a continual increase.
 - b.) 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.
 - c.) 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. Increase timeliness of investigation completions.

Program Activities

1. Conduct CD 101 and 303 trainings in Union County in 2010-2011.
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 STDs, 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.) CHD applied for and received an AmeriCorps VISTA grant and benefited from the work of two VISTA volunteers working on various public health issues with a social marketing intervention.
- d.) Union County was awarded a Tobacco Prevention and Education Program (TPEP) grant and associated activities have now been in place for two years.
- e.) Oregon Health Sciences University (OHSU) School of Nursing at Eastern Oregon University is in the middle of a community-based participatory research project focusing on childhood obesity called U.C. Fit Kids. CHD staff participates as a member of the coalition.
- f.) The School-Based Health Center at La Grande High School is continuing to provide services to Union County youth.
- g.) CHD secured a planning grant to look at adding a School-Based Health Center to in one of our rural school districts.
- h.) CHD is nearing the end of its second year of the Health Network for Rural Schools Program that was previously administered by OHSU School of Nursing.
- i.) CHD's has been working to address youth suicide utilizing prevention funds that will no longer be available after June 30, 2010.

2. Current Problems

- a.) Health reform legislation includes funding for home visiting programs, but the funding will 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.) 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.
- c.) 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. 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.
- d.) Long term increasing trend of women smoking during pregnancy. Last data available for 2007 is 18.2%.

- e.) 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.
- f.) 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.
- g.) In 2007-2008, 16.5% of eighth graders and 17% of 11th graders reported having a physical health need during the last 12 months that was not met.
- h.) In 2005-2006, 34% of eighth graders and 36% of 11th graders reported that a doctor, nurse or other health professional has told them they have one or more chronic health conditions.
- i.) Asthma is a serious issue for Union County youth ages 0-17 years. Union County has one of the highest overall asthma control scores (indicating poor asthma control) among children ages 0-17 years that were on Medicaid and is one of the counties with the highest rates of Emergency Department visits for asthma. In 2007-2008, 18.1% of eighth graders and 20.7% of 11th graders reported that a doctor or nurse had told them they had asthma.
- j.) In 2007-2008, 27.9% of eighth graders were overweight or obese, up from 25.4% in 2005-2006. 27.1% of 11th graders were overweight or obese in 2007-2008, up from 25.9 in 2005-2006.
- k.) 11.4% of eighth graders and 14.3% of 11th graders seriously considered suicide.

Program Goals

1. Sustain vital 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. Increasing the number of young children who use some dental sealant method.
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 all schools in Union County.
8. Decrease the rate of adolescents who are at risk for being overweight.
9. Decrease percentage of 8th and 11th graders who attempt suicide.

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. TPEP Coordinator continues working with schools on tobacco free policies. Three of the six schools in Union County have adopted gold standard model tobacco free schools policies and received a grade of 'A+' by the American Lung Association in Oregon. One school district received a grade of 'B' and the other two districts have policies that are rated as 'Incomplete.' We are continuing to work with personnel from those three school districts to improve their tobacco free school policy and move toward adoption of gold standard model policy.
5. 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.
6. Investigate and develop varnish program for home visiting clients.
7. Implement varnish program for home visiting clients.
8. 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.
9. CHD will continue to assume responsibility for administration of the Health Network for Rural Schools program to ensure a continuing health care presence in all non-La Grande schools in Union County.
10. CHD will continue planning for an additional School-Based Health Center in one of the rural school districts.
11. Continue to have CHD participation in U.C. Fit Kids coalition.
12. Continue with WIC nutrition classes and referral of high risk kids to dietician.
13. CHD has moved to a new facility that includes a community kitchen for nutrition and cooking classes/practice.
14. Start volunteer run cooking class for cooking nutritiously on a budget.
15. Explore options for continuing suicide prevention activities after grant funding ends.

Program Evaluation

1. Track vital statistic rate for smoking during pregnancy and among youth in schools. TPEP coordinator will share data received via TPEP with relevant CHD staff. Resources include Oregon Tobacco Facts, etc.
2. Track number of varnish applications with home visiting clients through Orchid system.
3. Track efforts to increase the number of pregnant women receiving prenatal care and accessing dental health services.
4. Track progress toward planning and implementing efforts designed to improve nutrition among youth and families.
5. Monitor presence in Union County schools and progress toward increasing school-based services.
6. Track youth suicide attempt rate through Oregon Health Teen data.

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

Current Conditions and Problems for Immunization Program

1. Current Conditions
 - a.) An H1N1 Influenza vaccination campaign was conducted in fall 2009.
 - b.) The number of 24-35 month olds covered with the 4:3:1:3:3:1 series increased to 73% in 2008, up from 57% in 2006 and 2007.
 - c.) Due to a Pertussis outbreak in fall of 2007, CHD conducted mass immunization clinics in local middle schools and high schools.
 - d.) Currently targeting sixth graders for TDAP immunizations in order to meet school immunization requirements.
 - e.) Currently targeting preschool age children in the county for Hepatitis A immunization in order to meet 2009-2010 school immunization requirements.
 - f.) VISTA volunteer focused on developing the immunization coalition and working to increase the rate of up to date immunizations in two year olds.
 - g.) New Immunization Information System will be rolling out this year, meaning changes for providers in our community.
2. Current Problems
 - a.) H1N1 took a lot of time and resources, making it difficult to focus on increasing rates of immunization for other vaccine preventable illnesses.
 - 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, 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 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 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.

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 all schools in the county.
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 for Hepatitis A and seventh grade for TDAP.
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
<p>A. Increase Up-to-date rate (4-3-1-3-3-1 series) of 2 year olds seen at Union County CHD by 1% or better every year</p>	<ul style="list-style-type: none"> 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 clients needing shots are referred to immunization program for vaccines Collaborate with Child Care Resource and Referral to provide vaccine education to the childcare providers and parents 	<ul style="list-style-type: none"> 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 Immunization 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 	<p>*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 2009.</p> <p>*The IRIS quarterly review data shows the percentage of data entered within 14 days was 59%.</p> <p>*Reception staff has developed a tickler system using IRIS in order to assess past due shots and forecast next shots due.</p> <p>*WIC staff assesses their client records with each appointment and makes referrals to PH staff if the child is past due on immunizations.</p> <p>*Up-to-date rates for CHD 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.</p> <p>*Union County immunization coordinator has conducted 3 site visits involving immunization education, record reviews for registered children and provided written materials for parent education.</p>	<p>*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.</p> <p>*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.</p> <p>*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.</p> <p>*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.</p> <p>*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.</p> <p>*There is an ongoing effort to increase rates further using: reminder/recall systems, community education and outreach, and collaboration with other health care providers.</p>

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

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

Year 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>	<ul style="list-style-type: none"> Immunize all sixth graders in the county with the TDAP immunization by holding shot clinics in schools. Target preschool-age children for Hepatitis A vaccines by holding multiple preschool immunization clinics at all elementary and preschools in Union County Coordinate with Health Network for Rural Schools nurse and school staff to conduct clinics and keep ALERT updated. Create system so Health Network for Rural Schools nurse & school staff can report all immunizations to ALERT (or to IRIS if CHD enters the data) 	<ul style="list-style-type: none"> Number of elementary school clinics held: ___. Number of children immunized: ___ Number of pre-school clinics held: ___. Number of children immunized: ___ Coordination meetings held with HNRS on [dates] 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. *Six clinics have been held for preschool age children. An estimated 50 children were vaccinated through these clinics. *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. *Following immunization clinics, VAR forms are promptly submitted to CHD and entered into the data base. This is reflected in the previously stated quarterly review number. *Immunization coalitions have been held quarterly, resulting in at least quarterly connections with local providers to increase knowledge.</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. *Additional clinics will be held periodically (at least quarterly) in attempt to reach all children *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>
<p>C. Continue community outreach to increase knowledge regarding immunizations and local rates.</p>	<ul style="list-style-type: none"> Continue quarterly coalition meetings. Continue outreach among local health care providers to provide education and training. 	<ul style="list-style-type: none"> Number of meetings held and frequency Number of connections with local health care providers 		

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) Results ⁵	Progress Notes ⁶
<p>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</p>	<ul style="list-style-type: none"> • 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 clients needing shots are referred to immunization program for vaccines • Continue collaboration with Child Care Resource and Referral 	<ul style="list-style-type: none"> • 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, 2010 	<p>-Efforts are made at each appointment to encourage parents to have their child receive all immunizations due at the time of the visit.</p> <p>-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.</p> <p>-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 with refer patients to the RN for detailed information and education as needed.</p> <p>-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.</p> <p>-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.</p> <p>-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.</p> <p>-Continued collaboration with the WIC program takes place. WIC staff will review the immunization 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.</p> <p>-Union County immunization coordinator works closely with CCRP 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.</p>	<p>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:</p> <ul style="list-style-type: none"> -Quarterly immunization coalition meetings with physicians, nurses, school representatives, parents and vaccine advocates: <ol style="list-style-type: none"> 1. July 23, 2009: The importance and safety of vaccines. 2. November 5th, 2009: H1N1 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. Attended "kindergarten roundup", an informational forum for parents on school exclusion and immunization law. <p>We plan to continue these efforts and work to create new routes of communication and education on the importance of vaccines.</p>

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.

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>	<ul style="list-style-type: none"> Continue Immunizing all sixth graders in the county with the TDAP immunization and holding shot clinics in schools Continue targeting preschool-age children for Hepatitis A vaccines by holding multiple preschool immunization clinics at all elementary and preschools in Union County Continue coordinating with Health Network for Rural Schools nurse and school staff to conduct clinics and keep ALERT updated 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) 	<ul style="list-style-type: none"> Number of elementary school clinics held: __. Number of children immunized: __ Number of pre-school clinics held: __. Number of children immunized: __ Coordination meetings held with HNRS on [dates] All shot records entered into IRIS or ALERT within 14 days of vaccine administration 	<p>Elementary clinics: -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> <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 Hepatitis 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>C. Continue community outreach to increase knowledge regarding immunizations and local rates.</p>	<ul style="list-style-type: none"> Continue quarterly coalition meetings Continue outreach among local health care providers to provide education and training 	<ul style="list-style-type: none"> Number of meetings held and frequency Number of connections with local health care providers 	<p>*Immunization coalitions have been held quarterly, resulting in at least quarterly connections with local providers to increase knowledge.</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) Results ⁹	Progress Notes ¹⁰
<p>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</p>	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<p>To be completed for the FY 2011 Report</p>	<p>To be completed for the FY 2011 Report</p>

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.

Year 3: July 2010 – June 2011

Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹¹	Progress Notes¹²
<p>B. Increase access to Immunizations for pre-school and school-age children</p>	<ul style="list-style-type: none"> • Continue immunizing all sixth graders in the county with the TDAP immunization and holding shot clinics in schools • Continue targeting preschool-age children for Hepatitis A vaccines by holding multiple preschool immunization clinics at all elementary and preschools in Union County • Continue coordinating with Health Network for Rural Schools nurse and school staff to conduct clinics and keep ALERT updated. • 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) 	<ul style="list-style-type: none"> • Number of elementary school clinics held: ___. • Number of children immunized: ___ • Number of pre-school clinics held: ___. • Number of children immunized: ___ • Coordination meetings held with HNRS on [dates] • All shot records entered into IRIS or ALERT within 14 days of vaccine administration 	<p>To be completed for the FY 2011 Report</p>	<p>To be completed for the FY 2011 Report</p>
<p>C. Continue community outreach to increase knowledge regarding immunizations and local rates.</p>	<ul style="list-style-type: none"> • Continue quarterly coalition meetings • Continue outreach among local health care providers to provide education and training 	<ul style="list-style-type: none"> • Number of meetings held and frequency • Number of connections with local health care providers 	<p>To be completed for the FY 2011 Report</p>	<p>To be completed for the FY 2011 Report</p>

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.

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

Current Conditions and Problems Family Planning Clinics

1. Current Conditions

- a.) AmeriCorps VISTA has implemented social marketing program to increase family planning visits to women in need over the past two years with a focus on teen pregnancy prevention.
- b.) Increase in outreach and service provision with local schools.
- c.) Continued success in linking youth with family planning services through the School-Based Health Center located in the county's largest high school.
- d.) Currently engaged in planning process aimed at opening an additional School-Based Health Center to expand services to youth in rural districts.
- e.) Teen pregnancy prevention coalition is active and meeting monthly.
- f.) 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 between FY 2008 and 2009 from 1,557 to 1,867. The percentage of Women In Need served decreased from 44.3% to 40.2%.
- c.) 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.
- d.) Limited number of males accessing family planning services.

Program Goals

1. Increase percentage of male family planning clients from the current 0.3% to 2% or more over the next year.
2. 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.
3. 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. Create a 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 FP services.
4. Discuss methods to include males in pregnancy prevention activities at the teen pregnancy prevention coalition meetings.

5. Create/obtain and distribute outreach materials targeting males and family planning services. Visit and educational procedures will be revised to include HPV vaccine counseling and option to administer for each patient (began 3-1-10).
6. Documentation will be done by adding HPV vaccine check box to nurse flow sheet and the client history form.
7. VIS forms and VARs will be available in each clinic room.

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.

**FAMILY PLANNING PROGRAM ANNUAL PLAN FOR
UNION COUNTY PUBLIC HEALTH DEPARTMENT
FY '11**

July 1, 2010 to June 30, 2011

**Agency: Center for Human Development, Inc.
Peasley, R.N.**

Contact: Joelene

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

Problem Statement	Objective(s)	Planned Activities	Evaluation
Very low percentage of male family planning clients.	Increase percentage of male family planning clients from the current 0.3% to 2% or more over the next year.	<ol style="list-style-type: none"> 1. Review and update policy/procedures for male family planning services. Include reception and nurses in this process. 2. Create a 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 FP services. 4. Discuss methods to include males in pregnancy prevention activities at the Teen Pregnancy Prevention Coalition (TPPC) meetings. 5. Create/obtain and distribute outreach materials targeting males and family planning services. 	<ol style="list-style-type: none"> 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 TPPC work plan.

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

Problem Statement	Objective(s)	Planned Activities	Evaluation
Inconsistent HPV vaccine counseling and administration for FP clients.	1. Increase the number of Union County residents vaccinated against HPV over the next year by offering vaccine to all FP clients at contraceptive visits, pregnancy test visits, and annual exam visits.	1. FP visit and educational procedures will be revised to include HPV vaccine counseling and option to administer for each patient. Begin 3-1-10. 2. Documentation will be done by adding HPV vaccine check box to nurse flow sheet and the client history form. 3. VIS forms and VARs will be available in each clinic room.	1. Policy and procedure revisions complete. 2. Forms revised and in use. 3. Evaluate vaccine administration data from IRIS and ECHO.
	2. Increase the number of Union County residents vaccinated against HPV over the next year by offering vaccine to all FP clients that qualify for the 317 special HPV project.	1. FP intakes will include screening for VFC/317 eligibility, self-pay or insurance coverage for HPV vaccine.	1. Evaluate IRIS immunization data.

Progress on Goals / Activities for FY 10 (Currently in Progress)

The annual plan that was submitted for your agency last year is included in this mailing. Please review it and report on progress meeting your objectives so far this FY.

Goal / Objective	Progress on Activities
<p>Increase % of women in need aged 13-19 served in Union County compared to FY 2010.</p> <p>Increase male FP clients.</p>	<p>1. The FP nurse and the SBHC nurses are both doing contraceptive classes and STD classes in Union County high schools. The health teachers have been scheduling this when there is a new group of students. We have seen a small increase in teens coming into the clinic from the outlying high schools on Fridays.</p> <p>2. The VISTA volunteer has created and distributed advertising materials county-wide for FP services.</p> <p>3. With the help of our VISTA volunteer, the Teen Pregnancy Prevention Coalition was started again and the first meeting was held 12/10/09. The meetings are held on a monthly basis and there has been excellent community participation so far.</p> <p>4. Added Friday walk-in clinics to accommodate teens from the rural high schools that do not have school on Fridays.</p> <p>1. Policy and procedures are now in place for male FP visits.</p> <p>2. We have seen about 7 male clients in the FP program (compared to 0 for last year). We will continue to work on this goal for the FY 2011.</p>
<p>IUD insertion for FP clients</p>	<p>1. We received a training grant for our NP and she was able to have a local physician train her in IUD placement. The NP has been placing both types of IUDs independently since December 2009.</p>

Progress on Title X Expansion Funds:

Also, a reminder that supplemental “expansion funds” were awarded as part of your agency’s regular Title X grant again this year. These funds were awarded for the purpose of increasing the number of new, low-income clients by expanding the availability of clinical family planning services. Please report any progress on the use of these funds for the following purposes:

- X Increase the hours of your clinic(s), the number of staff available to see clients, the number of days services are available or offer walk-in appointments

CHD Public Health was able to add a walk-in clinic on Fridays to accommodate more clients as well as the teens in the outlying communities.

C. ENVIRONMENTAL HEALTH

Current Conditions and Problems

1. Current Conditions:

- a) CHD's Environmental Health Program remains in place with one 0.75 FTE Environmental Health Specialist Trainee (EHST). The EHST has plans to increase their work by up to 5 hours per week during the summer months when temporary restaurant inspections are at their peak.
- b) The Environmental Health Program has been administered at the county level for over four the years. Substantial progress has been made in stabilizing program funding.
- 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) The certification process required of all Oregon Environmental Health Specialist Trainees (EHST) to become Registered Environmental Health Specialists is not efficient or adaptable. The application to receive the EHST certification took 10 weeks to process. Within two years the EHST must have a total of 3,840 clock hours to meet the prescribed work experience. For a 0.75 FTE EHST it will take a minimum of 2.5 years to meet the prescribed work experience.
- b) Work flow for the EHST is complicated by the seasonal changes in the number of temporary restaurants in need of inspection.
- c) There is a language barrier with certain food service facilities whose primary language is not English and/or who speak very little English.
- d) 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.
- e) 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. Building Infrastructure

- a) The Environmental Health Program is still in the process of building itself to the level its employees and state programs require. The Program has made great

progress and is currently meeting minimum requirements, but infrastructure issues continue to come up and need to be addressed.

- b) The Environmental Health Program employee is an Environmental Health Specialist Trainee (EHST) who is not fully trained on independent job functions. This employee has a formalized plan of supervision involving a Registered Environmental Health Specialist who educates, trains, and advises the EHST employee.
 - c) Work toward developing an ongoing solution to the seasonal shifts that impact the work flow of the EHST.
2. There is limited awareness of local environmental health resources and issues such as air quality and asthma.
 3. Improved accuracy of environmental health data collection is needed.

Program Activities

1. Continue working toward our environmental health employee becoming a Registered Environmental Health Specialist.
2. Conduct health inspections of all licensed facilities in a timely manner.
3. Conduct inspections of unlicensed facilities as requested by those facilities; certified day care facilities, certified day care homes, jails, and juvenile detention centers.
4. Conduct health inspections of all public schools.
5. Conduct inspections of licensed temporary restaurants.
6. Properly track all temporary restaurant facilities in Union County.
7. Track all newly issued food handler cards.
8. Maintain scheduled testing and licensing for food handlers in Union County.
9. Perform investigations prompted by citizen complaints on potential health hazards in licensed facilities.
10. 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.
11. 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.
12. Develop an air quality communication program to inform Union County residents of current air quality conditions.
13. Establish protocol for certain telephone inquiries relating to mold, radon, and other environmental health requests.
14. Provide accurate Summarizations for the 2011 Licensed Facility Statistics Report.

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 availability of air quality information and protocols for typical environmental health inquiries.

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.) Union County Providers of child hood immunizations are entering immunization data in ALERT.
2. Current Problems
 - a.) Due to a shortage of staff time and fiscal resources, we are not always able to meet timelines for filing of certified death certificates.
 - b.) The prior Environmental Health Specialist did not enter complete data into the Phoenix system, resulting in inaccurate data from Union County.

Program Goals

1. Enroll physicians with biometric signature for EDRS.
2. Maintain/improve ratings for timeliness and accurateness of communicable disease reporting.
3. Improve accuracy/completeness of environmental health data.

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. See environmental health plan for activities related to goal of improve accuracy of environmental health data.

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 and environmental health reports for accuracy of data.

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.) CHD was assigned two AmeriCorps VISTA volunteers to implement a social marketing plan focused on health education and information in the areas of immunizations, family planning, local communicable diseases such as West Nile and Pertussis, smoking prevention/cessation targeted to young families, and mental health/substance abuse information targeted to teenagers.
- d.) 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.
- e.) Periodically public health staff writes Community Comments in the local newspaper addressing various health topics.
- f.) 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 the 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.

Program Goals

1. Keep community updated on current relevant communicable disease health issues.
2. Push information to segments of the community and partners serving them to increase community awareness of local issues related to childhood immunizations and family planning access.
3. Explore possibilities for expanding the reach of our services to those groups and individuals we face challenges in serving.

Program Activities

1. Implement parts of social marketing plan that can be continued in the absence of the VISTA volunteer.
2. Continue to keep Web site and social networking sites updated with current program and local health information.

3. Identify and have staff disseminate existing health information to relevant partners.
4. Work with the local newspaper, County staff and vector control program in disseminating timely public health information during mosquito season.
5. 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 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.
- d.) CHD serves as the Regional Lead Agency for Region 9 of the Hospital Preparedness Program. The Region 9 coordinator, the Union County public health administrator, and the emergency preparedness coordinator are very involved with regional activities. This includes regular attendance at regional board meetings and meetings with state staff and federal liaisons. The work of this program is closely aligned with CHDs preparedness efforts and our work together supports our county's needs.
- e.) CHD has used real events to practice our response plans like our flu clinic and Pertussis outbreaks along with conducting additional exercises as needed.
- f.) 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.) A number of new staff, including the public health administrator, has limited training in Incident Command Structure, CD 101 and 301, HAN, and other desirable emergency preparedness relevant training.
- 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 population 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.

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 population 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. Reinstitute joint emergency preparedness, communicable disease, environmental health, and hospital preparedness meetings.
3. Develop plans for serving vulnerable populations. Engage staff working with developmentally disabled and mental health communities in this process.
4. Develop feasible mass dispensing plan.
5. Conduct testing of 24/7 response system monthly.
6. 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. Meeting minutes for Hospital Preparedness Program and joint emergency preparedness, communicable disease, environmental health, and hospital preparedness meetings.
4. Review of plans for updates and completeness.

G. OTHER ISSUES

Current Conditions and Problems

1. Current Conditions

- a.) CHD has been successful in implementing TPEP activities and have now completed two years of the program.
- b.) Northeast Oregon Network (NEON), a collaboration of health care providers in Union, Baker and Wallowa counties, is now operating under its own 501(c)(3). They are currently developing a local health care coverage product and CHD is involved in the process.

1. Current Problems

- a.) Smoking rates, especially among pregnant mothers and youth, are on the rise in Union County.
- b.) Union County has a very high un-insurance rate of 26%. Over 50% of births in Union County are in the payment category of publically funded or charity care.
- c.) 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. Prevent further increases in smoking rate, and begin to see it decrease in three years.
2. Implement three partial solutions to local access to care issues in the next three years in partnership with NEON.

Program Activities

1. Implement TPEP grant action plan.
2. Support NEON in their efforts to increase health care access in Union County.

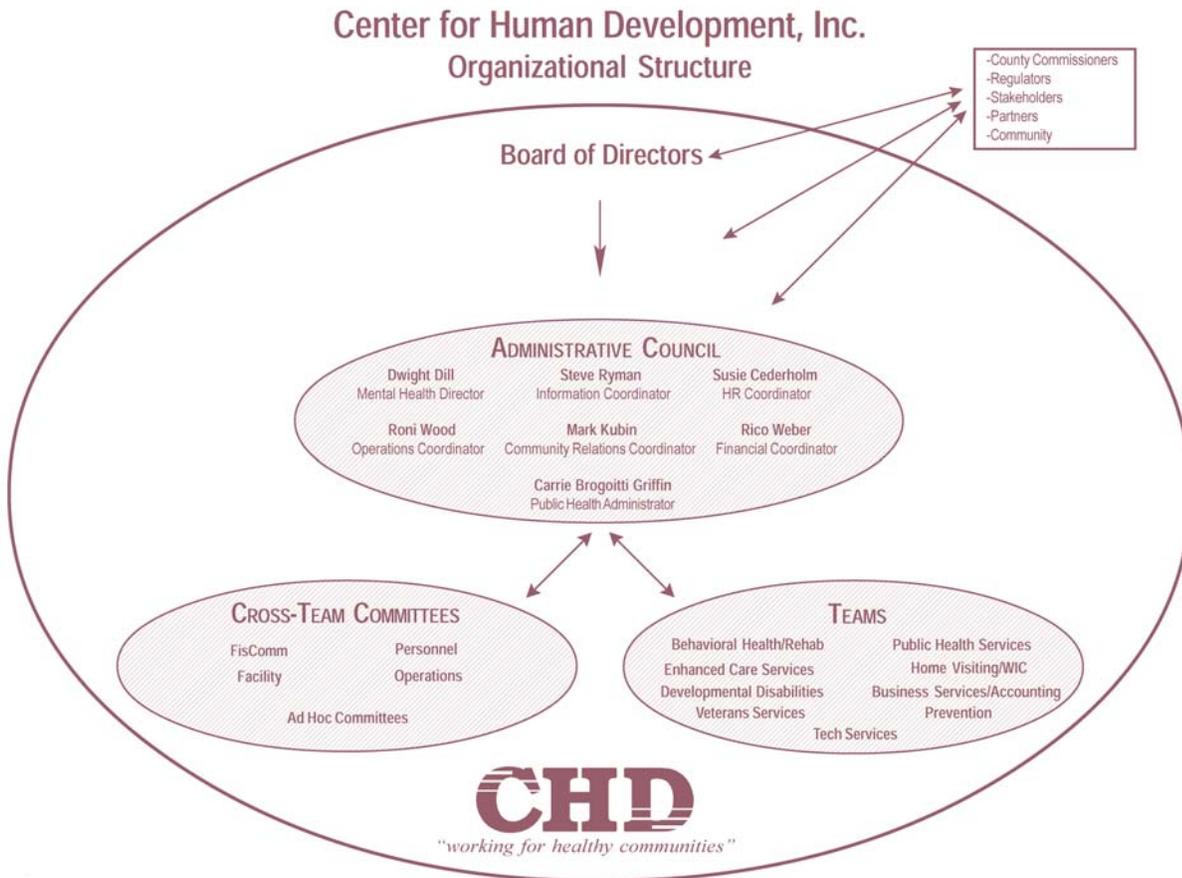
Program Evaluation

1. Monitor annual smoking rate.
2. 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.



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, CHD, is not the governing body that oversees the local Commission on Children and Families (CCF). The Local Public Health Authority (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 working with 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:

- **Population-Based Prevention Efforts:** Our organization struggles with finding resources to dedicate to “upstream” public health efforts aimed at addressing issues at the population level rather than focusing on treatment and containment of conditions/issues that have already occurred.
- **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, 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, OHSU School of Nursing withdrawing from two rural health clinics, 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
2009-2010**

Supported Program Element (PE)	Projected Award Amount Based on 2008-2009 Award
PE 01: State Support for Public Health	\$32,272
PE 03: TB Case Management	\$403
PE 12: Public Health Emergency Preparedness	\$83,648
PE 13: Tobacco Prevention and Education	\$54,018
PE 40: Women, Infants and Children	\$142,928
PE 41: Family Planning	\$21,822
PE 42: MCH-Title V – Flexible Funds	\$12,193
PE 42: MCH-Title V – Child and Adolescent Health	\$5,226
PE 42: MCH/Perinatal Health – General Fund	\$1,842
PE 42: MCH/Child and Adolescent Health – General Fund	\$3,457
PE 42: Babies First	\$5,833
PE 43: Immunization Special Payments	\$12,421
PE 44: School Based Health Centers	\$101,000

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.
1100 K Avenue
La Grande, OR 97850
541-962-8877
www.chdinc.org

VII. Minimum Standards

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

- | | |
|---|---------------------|
| Does the Administrator have a Bachelor degree? | Yes <u>X</u> No ___ |
| Does the Administrator have at least 3 years experience in public health or a related field? | Yes <u>X</u> No ___ |
| Has the Administrator taken a graduate level course in biostatistics? | Yes <u>X</u> No ___ |
| Has the Administrator taken a graduate level course in epidemiology? | Yes <u>X</u> No ___ |
| Has the Administrator taken a graduate level course in environmental health? | Yes <u>X</u> No ___ |
| Has the Administrator taken a graduate level course in health services administration? | Yes <u>X</u> No ___ |
| Has the Administrator taken a graduate level course in social and behavioral sciences relevant to public health problems? | Yes <u>X</u> 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, 2010
Date

Appendix E

EVALUATION OF WIC NUTRITION EDUCATION PLAN FY 2009-2010

WIC Agency: Union County

Person Completing Form: Patty Rudd and Linda Buckingham

Date: March 13, 2010 Phone: 541-962-8829

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

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

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

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

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

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

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

Response:

The new Food Package Module was completed by all staff prior to December 31, 2009. On July 14, 2009 all staff met at our computer center for a “on hands” practice session. Dates were entered into Twist.

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

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

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

Response:

Staff received training in “Interpreting Infant Feeding Cue” by Jane Heinig at the 2009 WIC Statewide Meeting. Staff not attending the 2009 WIC Statewide Meeting was given the DVD presented to local agencies by the state for onsite training.

We are using a new brochure from the University of California called “The 7 Secrets of Baby Behavior” and continue to counsel individual clients in all aspects of contact (intake, individual education contact, certification, home visiting, and 2nd nutritional education).

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

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

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

Response:

Lessons Plans were reviewed but not revised because we are not giving classes at this time.

Materials were reviewed and new materials were added that follow the key nutrition messages and new food packages.

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

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

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

FY 2009-2010 WIC Staff In-services

In-Service Topic and Method of Training	Core Competencies Addressed	Desired Outcome
Jean Farmer, Training Supervisor	Began in July 2009	
January 20, 2009 WIC Listens Continuing Ed.	At our team meeting, we discussed Opening the Conversation and Open-ended questions	To become more efficient PCE beginning the conversation and focusing on client participation.
February 9, 2009 In-service with Adrienne Mullock	Group discussion on Sharing and judgment and handling sensitive/difficult issues.	To share experiences and ideas for sustainability.
February 10, 2009 WIC Listens Cont'd Ed	Team meeting-group discussion on Affirmations and Reflections.	To be able to find opportunities to make supportive statements and develop deeper reflections.
February 24, 2009 WIC Listens Cont'd Ed	Team meeting-group discussion on Summarizing and offering Nutrition Ed.	To insure we understand the participant's concerns and complete the assessment before we ask permission to offer education.
March 10, 2009	Team meeting-group discussion about the use of printed materials and closing the conversation	To summarize key points, explore what they know, offer information, i.e. printed materials and explore next steps. Staff uses the Explore/Offer/Explore technique more consistently.

March 23, 2009 New Food Package In-service	New Food Package; Low Fat Milk, Formula change, Postpartum and infant anticipatory guidance and Medical documentation.	To become familiar with the new food packages prior to implementing them in August.
April 13, 2009 Adrienne Mullock	WIC listens-group discussion-sharing and focusing on summarizing, spirit versus skills.	Observe certifications with feedback for continued learning and practice.
May 12 th , 2009 Pickers Eaters	Team meeting group discussion. Shared new materials and ideas.	To offer new ideas and materials that we could all use.
June 23, 2009 2009 WIC Statewide Meeting	Fresh Choices in WIC, Infant Feeding Cues	To increase knowledge in the new food package changes and help solidify WIC's role as the premier public health nutrition program. Attended training with Jane Heinig on Infant Feeding Cues
September 28, 2009 PCE Training Baker City	Review PCE for WIC Listens with regional cohorts. Core competencies addressed.	To feel more comfortable using PCE. During training we explored ideas with other agencies.
October 12, 2009 In-service with Jean Farmer	Oral Health during Pregnancy and Infants	To understand the importance of good oral health during pregnancy and babies first year.
December 8, 2009 In-service with Patty Rudd	Physical Measurements	To do proper physical measurements.
January 25, 2010 With Jean Farmer	2 nd Nutrition Education Documentation	To consistently use the same method of documentation for 2 nd NE.
March 10, 2010 Baker City Kim McGee and Vernita Renya	PCE Training	To energize, strategize and plan for sustainable staff development

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

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

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

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

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

Response:

The most used core components are Opening the Conversation, Setting the Agenda, Asking Permission, Affirmations, Reflections, and Summarizing. These seem to come most naturally when talking with clients.

Setting the next steps seems to be the most difficult. It is sometimes hard to find the right questions to ask to help the client set the next step.

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

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

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

Response:

We held four different team meetings to have group discussion on core competencies.

Peer to Peer observations have been implemented.

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

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

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

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

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

Response:

We attended the Early Childhood Planning Team meeting which consists of several county agencies who deal with children and their families and met individually with Head Start.

Handed out information about the new fresh choices and explained the positive changes.

All agencies were very receptive of the new changes and are supportive.

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

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

- How did your agency collaborate with the state WIC Research Analysts in evaluating Fresh Choices?
- How were you able to utilize, if appropriate, information collected from your agency?

Response:

We have cooperated with Oregon State WIC program and they are handling the evaluation of fresh choices.

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

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

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

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

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

Response:

We identified the following strengths and weaknesses:

- ***Strength:*** *Promoting Breastfeeding through WIC and other programs such as Babies First!, MCM, and CaCoon.*
- ***Weakness:*** *Need for Lactation Educators and need for more breastfeeding education for clients. Also need to follow up with breastfeeding moms within 1-2 weeks postpartum.*

Strategies identified were to have staff attend Evergreen Perinatal Education Training and to implement not giving infants aged birth to one month formula. Training attended in April of 2009.

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

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

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

Response:

One strategy involved educating staff. We attended the Evergreen Perinatal Education Training in Spokane April 27 – May 1, 2009. Two staff members were certified as Lactation Educators.

Our next step is to participate in the quarterly breastfeeding meetings via teleconference to continue to improve upon our newly acquired skills.

We also have encouraged all pregnant mothers to breastfeed and not give any formula during the first month of life to establish a good milk supply.

FY 2010 - 2011 WIC Nutrition Education Plan Form

County/Agency: Union County Center for Human Development
Person Completing Form: Patty Rudd and Linda Buckingham
Date: March 16, 2010
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, 2010
Sara Sloan, 971-673-0043

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

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

Activity 1: WIC Training Supervisors will complete the Participant Centered Education e-Learning Modules by July 31, 2010.

Implementation Plan and Timeline:

WIC training supervisor will complete the Participant Centered Education E-learning module by July 31, 2010.

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

Implementation Plan and Timeline:

All WIC certifiers who participated in the Oregon WIC Listens 2007-2009 training will pass the posttest of the PCE E-learning modules by December 31, 2010. Our staff plans to do this as a group in-service.

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

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

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

WIC staff will attend the Group PCE regional training in fall 2010. Our local agency plans to send two staff members to the training. Those staff attending will be required to pass the posttest of the PCE E-learning modules by August 31, 2010.

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

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

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

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

Implementation Plan and Timeline:

We plan to use the Supporting Breastfeeding through Oregon WIC Listens tool to identify our strengths and weaknesses. With this tool we will be able to assess and plan for future efforts by March 31, 2011. All staff will complete the assessment tool by December 31, 2010.

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

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

Implementation Plan and Timeline:

We will attend the regional Group Participant Centered Education training in the fall so that we may begin to include, at our local agency; the evidence-based concepts that the state staff develops for breastfeeding education by March 31, 2011.

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

Year 1 Objective: During planning period, each agency will identify organizations in their community that serve WIC participants and develop strategies to enhance

partnerships with these organizations by offering opportunities to strengthen their nutrition and/or breastfeeding education.

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

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

Implementation Plan and Timeline:

We will identify our community partners that serve WIC participants and provide nutrition education by July 31, 2010. Once identified, we will contact them to develop strategies to enhance partnerships and strengthen nutrition and/or breastfeeding education by inviting them to attend a regional group participant centered education training in fall 2010.

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

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

Implementation Plan and Timeline:

Community partners identified in Activity 1 will be invited to attend an Oregon WIC Breastfeeding Basics training or to complete an online Oregon WIC Breastfeeding module. When specific registration information is available, we will contact our community partners with an invitation. Date to be determined.

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

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

Activity 1: Local agency staff will complete the new online Child Nutrition Module by March 31, 2011.

Implementation Plan and Timeline:

In order for staff to increase their understanding of the factors influencing health outcomes and provide quality nutrition education, staff will be required to complete the new online Child Nutrition Module by March 31, 2011

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

Agency Training Supervisor(s):

See Attachment A

Attachment A

FY 2010-2011 WIC Nutrition Education Plan

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

Agency: *Union County Center for Human Development, Inc.*

Training Supervisor(s) and Credentials: *Jean Farmer, Registered Dietician*

Staff Development Planned

Based on planned program initiatives, your program goals, or identified staff needs, what quarterly in-services and or continuing education are planned for existing staff? List the in-services and an objective for quarterly in-services that you plan for July 1, 2010 – June 30, 2011. State provided in-services, trainings and meetings can be included as appropriate.

Quarter	Month	In-Service Topic	In-Service Objective
1	July, 2010	Posttest for PCE e-learning	To complete the posttest as group to learn and utilize PCE skills and strategies in group settings
2	Fall 2010 Date TBD	Regional Group Participant Centered Education Training	To learn and utilize PCE skills in a group setting
3	December 2010	Supporting Breastfeeding through Oregon WIC Listens	To assess strengths and weaknesses to plan for future efforts.
4	March 2011	Child Nutrition Module online	Increase understanding of the factors influencing health outcomes in order to provide quality nutrition education.

Supporting Breastfeeding through Oregon WIC Listens

A local agency checklist to assess strengths and plan for future efforts

Assessment Area	Using the key below check the response that describes your agency's readiness level					Current Status	Ideas for Future Efforts
	1	2	3	4	5		
A. Breastfeeding Policies and Procedures							
1. Our WIC agency breastfeeding policy affirms the value of breastfeeding and influences all aspects of clinic operations.					x	Our agency is promoting breastfeeding and does not promote formula use. Our agency does not display any information on formulas.	To continue as we are doing.
2. Our WIC agency/county health department has applied for and received the state designation as a <i>breastfeeding mother friendly employer</i> and displays the certificate on site.					x	In our new facility we have a breastfeeding room. Our administration is proceeding with the application.	Follow up on state designation with administration. When certificate is received, it will be displayed.
3. Breastfeeding promotion knowledge, skills and attitudes are part of position descriptions and the employee evaluation process.			x			All staff members have had breastfeeding training and completed breastfeeding modules. Staff continues to promote breastfeeding with a high degree of commitment.	During peer to peer observations, we will look for skills and attitude during certification.
B. Staff roles, skills and training							
1. All WIC staff use Oregon WIC Listens skills when talking with pregnant women and mothers about breastfeeding.					x	Staff has been working on developing WIC Listens skills and continues to practice skills.	Make it a high priority to use PCE skills when talking with pregnant women and mothers about breastfeeding.
2. All WIC staff has completed the breastfeeding module level appropriate for their position.					x	All staff members have completed breastfeeding modules.	Will continue to use knowledge acquired.

1. Not doing and not ready to start; 2. Want to start; 3. Started and may want to do more; 4. Already doing quite a bit with room for improvement; 5. We're superstars!

Supporting Breastfeeding through Oregon WIC Listens

A local agency checklist to assess strengths and plan for future efforts

Assessment Area	Using the key below check the response that describes your agency's readiness level					Current Status	Ideas for Future Efforts
	1	2	3	4	5		
3. Our WIC agency has a sufficient number of staff who has completed a 5 or 6 day advanced breastfeeding training such as the Portland Community College Lactation Management course. (Note: A sufficient number based on your agency's caseload and the need for breastfeeding services.)					x	Two staff members attended.	Will try to take part in breastfeeding trainings provided by state.
4. Our WIC agency has an IBCLC on staff.	x					No one on staff.	Refer to IBCLC at children's clinic or the hospital when needed.
C. Prenatal Breastfeeding Education and Support							
1. WIC staff use Oregon WIC Listens skills to encourage pregnant women to share their hopes and beliefs about breastfeeding and respond accordingly.				x		We encourage all pregnant women to share hopes and beliefs whenever possible.	Continue good efforts.
2. WIC staff helps women to recognize their own unique strengths which will help them breastfeed successfully.				x		We continue to do all we can to help breastfeeding women be successful.	Continue to encourage women and recognize their strengths.
3. WIC staff prepares women to advocate for themselves and their infants during the hospital or home birth experience.				x		We try to encourage women to have a birth plan in place for themselves.	Continue to have women advocate for themselves and their babies.
4. WIC staff encourages women to fully breastfeed, unless contraindicated.					x	We always encourage our clients to fully breastfeeding when possible	Same as current status.

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Supporting Breastfeeding through Oregon WIC Listens

A local agency checklist to assess strengths and plan for future efforts

Assessment Area	Using the key below check the response that describes your agency's readiness level					Current Status	Ideas for Future Efforts
	1	2	3	4	5		
5. Women planning to combine breastfeeding and formula feeding are informed of the impact on breastfeeding and potential health risks.					x	We try to inquire about the choice to combine breastfeeding and Formula and inform them of the impact. We support our clients at all times.	Continue the same.
6. WIC staff teaches women infant behavioral cues and how these relate to breastfeeding success.				x		We inform mothers of the secrets of babies' behavior and cues prior to delivery.	Continue to inform mothers and use the handout "the 7 secrets of babies' behavior".
7. WIC staff helps women prepare for breastfeeding after returning to work or school.					x	We always support our breastfeeding mothers and inform them of the option to use breast pumps.	Continue to give out breast pumps to working mothers as long as available.
D. Postpartum Education and Support							
1. Our WIC agency offers breastfeeding support throughout the postpartum period.				x		Staff always encourages breastfeeding as long as possible.	Continue to offer breastfeeding support.
2. Staff members contact each breastfeeding mother within 1-2 weeks of expected delivery to assess any concerns or problems and to provide assistance.			x			We don't do this on a regular basis because of time constraints.	We will plan to schedule a time weekly to make regular calls to our postpartum breastfeeding women.
3. WIC staff with advanced breastfeeding training is available to assess, assist and/or refer all mothers requesting breastfeeding help within 1 business day				x		We have 2 staff members who have completed the Evergreen Perinatal training available.	Same current status.

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Supporting Breastfeeding through Oregon WIC Listens

A local agency checklist to assess strengths and plan for future efforts

Assessment Area	Using the key below check the response that describes your agency's readiness level					Current Status	Ideas for Future Efforts
	1	2	3	4	5		
of her contacting the WIC office.							
4. WIC staff encourages and support mothers to fully breastfeed throughout the postpartum period, unless contraindicated.					x	We always encourage our clients to fully breastfeeding when possible	Continue to support WIC Mothers throughout postpartum period.
5. Breastfeeding mothers wanting to combine breastfeeding and formula feeding are informed of the impact on breastfeeding and potential health risks						We try to inquire about the choice to combine breastfeeding and formula and inform them of the impact and potential health risks. We support our clients at all times.	Same as current
6. WIC staff teaches women about infant behavioral cues and how these relate to breastfeeding success.				x		Both pregnant and postpartum mothers are informed on infant behavioral cues.	Continue to inform moms.
7. Our agency provides breast pumps when needed.					x	We have breast pumps available for breastfeeding moms going back to work or school to keep. We also offer hospital grade pumps to moms having breastfeeding problems on loan basis.	Continue to offer breast pumps as needed.

1. Not doing and not ready to start; 2. Want to start; 3. Started and may want to do more; 4. Already doing quite a bit with room for improvement; 5. We're superstars!

Supporting Breastfeeding through Oregon WIC Listens

A local agency checklist to assess strengths and plan for future efforts

Assessment Area	Using the key below check the response that describes your agency's readiness level					Current Status	Ideas for Future Efforts
	1	2	3	4	5		
E. Breastfeeding Food Packages							
1. WIC staff assesses each pregnant woman's breastfeeding intentions and provide information about how WIC supports breastfeeding including no formula issuance in the first month postpartum.					x	We have continued to inform moms that if they are breast feeding and supplementing, we do not offer formula for the first month of baby's life.	We plan to continue to follow the food package guidelines for infants and hope this encourages mothers to breastfeeding more.
2. A WIC CPA completes an assessment when a breastfeeding mother requests formula and tailors the amount of formula provided. Breastfeeding assistance is also provided to help the mother protect her milk supply.				x		The most important goal is to build milk supply so we are careful to assess mom's breastfeeding needs.	We will continue to emphasize how important it is to protect and build milk supply. If assistance is needed beyond our scope of service, we will refer to an IBCLC.
F. Creating a community that supports breastfeeding.							
1. Our agency participates in a local breastfeeding coalition, task force, and/or the statewide Breastfeeding Coalition of Oregon (BCO).		x				We have no local coalition but belong to the statewide Breastfeeding Coalition of Oregon.	We will participate and be more active with the BCO.

1. Not doing and not ready to start; 2. Want to start; 3. Started and may want to do more; 4. Already doing quite a bit with room for improvement; 5. We're superstars!

Supporting Breastfeeding through Oregon WIC Listens

A local agency checklist to assess strengths and plan for future efforts

Assessment Area	Using the key below check the response that describes your agency's readiness level					Current Status	Ideas for Future Efforts
	1	2	3	4	5		
2. Our agency staff collaborates with nurses, lactation staff and physicians at area hospitals to support breastfeeding in the community.			x			We work with other local agencies to support breastfeeding but have no regular working collaboration.	It would be nice to work toward creating a local coalition.
3. Our agency staff communicates with local medical providers on a regular basis to promote breastfeeding and WIC services.			x			We do not have a lot of communication with local medical providers due to their schedules.	It would be good to develop a closer working relationship.
4. Our agency works with breastfeeding peer support organizations in the community such as La Leche. If no organizations are available, write in N/A						N/A	N/A
5. Our agency promotes breastfeeding through local media.	x					Not at this time	Will try to do more promotion through the local media.

1. Not doing and not ready to start; 2. Want to start; 3. Started and may want to do more; 4. Already doing quite a bit with room for improvement; 5. We're superstars!