Local Public Health Authority Annual Plan
Planning Instructions FY 2005 - 2006
Amended (Morrow County)

I. EXECUTIVE SUMMARY
(Amended Portion Only)

The only significant change that should be noted is that we are planning to begin offering Environmental Health services directly through our Health Dept. at the start of the next calendar year (Jan. 2006). At this point, the plan is to have a contract in place with Umatilla County Public Health. This will be in the form of some type of an agreement (most likely a formal contract) with Umatilla County. This position would be housed in the Umatilla office and would provide services to our county through outreach from this primary office, much like the program that is provided through the 9-county EH district that is currently in place, but on a more thorough and effective basis. The current program is unable to provide this level of service currently due to the limited staff available.

II. ASSESSMENT
(Amended)

ALCOHOL & DRUG USE: As you are aware, there has been a return of some of the services offered through the OHP that had temporarily been suspended. Although the provision for services has been restored, I understand that there is a gap in covered services for the actual screening to assess the need for services. This past year our county Behavioral Health Dept. applied/received funding through the local CCF to address this missing piece needed to provide appropriate referral for ongoing counseling services as warranted. Since then the funds have been expended and although I know they have applied for a renewal of that same grant, it is uncertain if funding will be available.

EMERGENCY PREPAREDNESS: We continue to be actively involved with our local CSEPP including collaboration and participation in their annual exercise. We are in the process of procuring secure wireless access across a large portion of the county (geographically). We currently have memorandums of understanding in place with Umatilla County (we were in the process of obtaining this last year).

FOOD BORNE ILLNESS: It was noted in the last annual plan that our local dept. response was limited to investigation and follow-up as indicated. We continue to have a district wide Environmental Health component that is provided via the state which will change to local control Jan. 2006. We now anticipate that this will be addressed as a contract with the Umatilla County Health Dept. in which they will then provide the EH services. Additionally we had two staff members attend the Environmental Health orientation in our efforts to be more prepared for the change in services and to have a better understanding of those services.

IMMUNIZATIONS: We have noted a slight decline in immunization rates for our county including "percent of 24-month olds fully covered with the 4:3:1:3:3 series" and we are now in the process of implementing a plan to address our rates.

SAFETY NET MEDICAL SERVICES: The County did receive funding for the FQHC which we were in the process of submitting last year. They opened officially in January of this year, offering another resource for services for those lacking a medical home in the past.

Describe adequacy of the basic services

Describe the adequacy of the local public health services.

Describe the extent to which the local health department provides the five basic services contained in statute (ORS 431.416) and rule.

Extent to which Morrow County Health Department provides the five basic services contained in statute (ORS 431.416)
(Amended portion only)

Environmental Health. The only change is in reference to the provision of Environmental Health services as they will be offered at the local level through a contract with Umatilla County (as stated earlier in this plan).

Describe the adequacy of services the "...health department should include or provide for programs..." (OAR 333-014-0050 (3))

Dental - No change at this time.
Emergency preparedness - No change at this time.
Health education and health promotion - No change at this time.
Laboratory services - No change at this time.
Medical examiner - No change at this time.
Nutrition - No change at this time.
Older adult health - No change at this time.
Primary health care - No change at this time.
Shellfish sanitation - No change at this time.

III. ACTION PLAN
(Amended)

1. <u>Control of reportable Communicable Diseases</u> (OAR 33-014-0050 (2) (a)).

A. Current Condition or Problem. Previously I had stated the desire for staff to be trained in responding to CD's as well as bioterrorism events. Additional staff have been trained in CD (both CD 101 and 303) in the past year as well as participated in other training related to bioterrorism.

B. Goals. The knowledge base of the Nursing staff has been increased throughout this past year. The goal is that additional learning will take place this next year with all of the nursing staff having received both of the CD trainings with ongoing BT training as well.

C. Activities. As stated above, activities include all nursing staff receiving training regarding CD investigation and follow up as well as ongoing BT training.

D. Evaluation. Unchanged.

2. <u>Parent and Child Health</u> (OAR 333-014-0050 (2) (b)).

A. Current Conditions or Problem. In this past year we have been able to increase the FTE (by a few hours) of two of the nursing positions. One of the positions went from 0.8 to 1.0 FTE and the other position was increased from 0.49 to 0.8 FTE. Of these increased hours, a portion will be to increase hours in home visiting (MCM, Babies First, CaCoon and Healthy Start). The other increase in hours will be within OMC and the BCC program.

***B.* Goals.** The goal to increase nursing hours has been partially met (it is not by a full 1.0 FTE as was the goal). The next goal will be to actually have come to now appreciate an increase in the services we are able to provide within the home visiting program.

C. Activities. We have been able to show increased revenues in MAC billing as well as fee for services. We are also planning on having an increase in funds with a limited number of TCM visits.

D. Evaluation. This will be based on the addition of home visiting services offered.

3. Health Statistics (OAR 333-014-0050 (2) (c)).

No change at this time.

4. Information and Referral (OAR 333-0014-0050 (2) (d))

No change at this time.

5. Environmental Health (OAR 333-014-0050 (2) (e))

A. Current Condition or Problem. As previously mentioned earlier in this plan, we will be providing Environmental Health services at a local level beginning Jan. 2006. This will be accomplished by contracting with Umatilla County through their EH program.

B. Goals. The goal is to be providing Environmental Health services at a local level.

C. Activities. Entering into an agreement with Umatilla County for the provision
of Environmental Health services.

D. Evaluation. Based on the provision of Environmental Health Services at the local level

6. Tobacco.

No change at this time.

7. Breast and Cervical Cancer.

We continue to have difficulty accessing the 50-64 year age group in spite of our continued efforts. A small portion of the increased nursing FTE will be to benefit the BCC program. Please see the BCC self evaluation and plan for further info.

8. Diabetes.

No changes at this time.

9. Asthma.

No changes at this time.

10. Water.

No changes at this time.

11. Bioterrorism.

No changes at this time.

12. HIV.

The two nurses that we had planned to attend/receive HIV training last June have obtained the training in addition to all of the nurses attending the HIV training on rapid testing. No other changes at this time.

13. TB.

We are in the process of rewriting our TB program protocols. No other changes at this time.

14. Immunizations.

See separate plan developed for this program.

15. Family Planning.

No changes at this time.

16. Child and Adolescent Health.

See previously mentioned increase in FTE. No other changes at this time.

17. Perinatal Health.

See previously mentioned increase in FTE. No other changes at this time.

18. Babies First.

See previously mentioned increase in FTE. No other changes at this time.

19. WIC.

No changes at this time.

20. West Nile Virus.

There is currently an Eastern Oregon West Nile Virus Task Form in which the BT/CD nurse actively participates. No other changes at this time.

IV. ADDITIONAL REQUIREMENTS
(Amended)

1. Family Health Programs (2004 – 2006)

Perinatal Health Program Plan:

We currently receive a program specific grant for OMC. There are no changes in the plan to provide care in any of the areas.

Child Health Program Plan:

Babies First – Total FTE for this program is now 0.3 FTE. This is not a huge increase in overall hours but is an improvement from last year which will result in the provision of additional TCM services.

Adolescent Health Program Plan:

The school no longer honors the provision of a note from the Health Dept as an "excused absence" from class to obtain services. This decision was based on the written policy of the school district allowing notes for excused absences to be submitted by parents only. This is a bit of a barrier but the clinic is open during the scheduled lunch period/s and the nurses try to be sensitive to this issue, taking the client in and providing the service as quickly as possible. For some of the students (where transportation or accountability is not as issue) it has not been a problem to come to clinic after school hours. There have been no other changes in the delivery of services.

Women's & Reproductive Health Program Plan:

No changes at this time.

Immunizations:

FY 2006 Plan will be forthcoming directly to the Immunization Program.

BCC Program:

See specific program plan for updates, changes and/or additions since submitting last year's plan.

WIC:

Not applicable as these services are provided outside of the local Health Department.

2. Organizational Chart:

There have been some minor changes in FTE as well as a few changes in employee names. The number of employees and the overall chart remains unchanged (See attachment).

3. The LPHA:

There have been no changes in the governing body.

V. UNMET NEEDS
(Amended)

No real changes overall in the narrative previously submitted for FY 2005. The primary need which is high importance continues to be the unavailability of Prenatal care within the county. As you know via the Perinatal plan, there are MCK dollars allocated to paying a stipend for a limited number of income eligible prenatal clients. As I mentioned earlier in the Annual Plan, we did receive funding for an FQHC (we were in the application process one year ago) and there are plans to include prenatal care as part of the services offered. There had not yet been a system implemented for that care to be available and negotiations are currently in progress to contract with an OB/GYN from Hermiston. What is not yet clear is if these services will be offered "in house" here in the FQHC (in Boardman) or if clients would still be required to travel to Hermiston to access care through out their pregnancy. Dental care continues to be an issue as well, although there is an agreement in place with the FQHC to access emergency dental care only through the local dental office. The only other change since the original narrative would be the reference to the loss of mental health services, some of which have been reinstated via the OHP program.

VI. BUDGET.
(Amended)

The budget for FY 2006 has been tentatively accepted by the budget committee pending final approval. I do not have this document available electronically, thus I will send a copy of the proposed FY 2006 budget with the hard copies of the Annual Plan amendments.

VII. MINIMUM STANDARDS
(Amended)

Organization:

No change at this time.

Control of Communicable Disease:

No change at this time.

Environmental Health:

There will be changes in the provision of Environmental Health as a contract service with Umatilla Public Health beginning Jan. 2006. There are no current plans to include the provision of Drinking Water at this time.

Health Education and Health Promotion:

No change at this time.

Nutrition:

No change at this time.

Older Adult Health:

No change at this time.

Parent and Child Health:

No change at this time.

Primary Health Care:

No change at this time.

Cultural Competency:

No change at this time.

Health Department Personnel Qualifications:

No change at this time.

Send us a statement:
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. The Annual Plan posted at

http://www.dhs.state.or.us/publichealth/lhd/lhd-annual-plan.cfm

is complete and current for our county, with the addition of amendments submitted for 2005 – 2006 fiscal year.

*	**Morrow**	**05/02/05**
Local Public Health Authority	County	Date

*** See attached signed copy with the paper copy of the 2006 Annual Plan.**

OFFICE OF FAMILY HEALTH
COUNTY ANNUAL PLANS FY 2006

IMMUNIZATION PROGRAM

Summary of FY 2003-05 Objectives, Activities, and Outcomes

Vaccine Accountability

Progress in FY 2005:

Objectives:

To develop long-term strategies to reduce and maintain the percentage of unaccounted for vaccine to less than 5% of total vaccine handled.

Overall, there have been a lot of positive changes within our Vaccine program over the last two years particularly in the area of accountability. Many strategies were implemented to improve our program such as storage issues, accuracy of vaccine counts, usage of vaccine with the closest expiration, etc.

We have made progress regarding unaccounted vaccines although we continue to struggle with total accuracy of number of doses given compared with the actual count of vaccine stock.

Activities as listed FY 2005:

Monthly vaccine orders to be ordered only on the 5th day of the month.

There has been improvement in our ordering system, more consistently ordered one time per month, but I can't report that this has always been practiced. We have continued to have times when it has been necessary to make "special" and at times, urgent order requests for additional vaccine supply.

Assign back up staff to place vaccine orders as needed.

There is back up staff assigned to place vaccine orders as needed.

Apply stickers to current use stock.

We began placing stickers on current use stock but found it to be unnecessary as we also mark every box with the exp. Date, and we place each type of vaccine in a separate basket with the current use stock in the front of the basket. We have since done away with the "current use" basket that had different kinds of current use stock/vaccine as we felt that this may add to the possibility of medication error.

Develop a reminder system for the nurses re vaccine accountability.

The date to count vaccine is now listed on our monthly calendar on the date that most closely coincides with the 25th of the month and the date that the nurses will be in the clinic, available to count. The date listed for the vaccine count on the calendar then acts as a reminder for all staff to ensure this activity is done.

We have certainly been successful in the overall goal of increased awareness of all staff regarding vaccine accountability.

Measurable Outcomes: Monthly inventory to be comparable to previous months and year with percent of unaccountable vaccine to be less than 5%. I do not have our current percentage to compare but I do not believe it is less than 5%.

ALERT Promotion

Progress in FY 2005:

Objectives:

To develop long-term strategies to promote ALERT.

This area is still a work in progress as all of the schools were contacted and training was offered to all, but ultimately took place at the school district office with a limited number of school staff in attendance. There are current plans for FY 2006 to continue efforts to provide continued as well as additional supports to continue to promote school staff usage of ALERT.

Identify schools not yet enrolled.

As noted above, although this area was addressed initially, there is need of continued work to identify those schools that continue to use the system as opposed to those who started the process but did not continue versus those who are still not enrolled. See the current FY 2006 plan for further info

Promote the ALERT website here in our county.

This activity has been done and continues to be ongoing. This will also be revisited in the current fiscal year.

Activities as listed in FY 2005:

Vaccinations to be entered into the system during the clinic in which service was obtained. In addition, enrollment and training to all staff regarding the use of ALERT was to be done.

The initial intent was to enter all of the vaccines at the time of service but we soon found that when clinic was especially busy, particularly coupled with the dual duty of Lay Health Promoter (LHP's) to provide translation this was a difficult process. This activity was then modified to include the use of ALERT in conjunction with the IRIS system to identify the recommended vaccine only. Additionally it was felt that if vaccines were entered under this type of pressure, mistakes were more likely to occur.

Identify schools not currently participating in ALERT ; provide an opportunity for enrollment and training; DHS and/or local staff to work with the schools to promote successful usage of ALERT.

All of the activities listed above were done with each school being contacted, opportunity for training provided and DHS staff worked with local staff to promote ALERT. What is now needed is continued follow up of the activities that were initiated for on going success of those schools utilizing ALERT as well as those who are not.

Prioritize schools according to size; designate person/s responsible for visiting the schools; develop an initial training; and begin actual school visitation.

All of the activities listed above were done with varying levels of success at the actual school level. I believe it is now imperative for this activity to have a follow up component to ensure ongoing/continued success at the school level.

Measurable Outcomes:

Measured by the number of vaccines entered into the system during the clinic in which vaccine was obtained.

As mentioned above, this activity was abandoned in its "purest" form although the use of ALERT is certainly present at the clinic level, at the time services are rendered.

Increased awareness and usage of the ALERT system by the county schools.

This outcome was attained regarding both the awareness of and usage by the county schools. There is however, more work that can and will be done.

Increased numbers of schools enrolled in and accessing ALERT.

Again, although this area was addressed with significant progress made, there is more work that can be done to improve the current level of use. We will continue to work in this area throughout FY 2006.

Educational Outreach Activities

This is N/A as this activity was not chosen.

WIC/Immunization Integration

This is N/A to our county as WIC services are not provided through the Health Dept.

Local Health Department: Morrow County
Outreach Activities: July 2005 – June 2006

Activity 1: Community Outreach				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results[1]**	**Progress Notes[2]**
A. **Raise awareness of recommended Flu and other age related vaccine of county population (all).**	• Media Campaign: Newsprint ADs, local public TV station and flyers to educate the public regarding recommended vaccines and availability.	• Ask clients accessing service immed. following the ADs; how they became aware of vaccine need/availability.	To be completed for the FY 2006 Report	To be completed for the FY 2006 Report

Activity 2: Community Outreach				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results[1]**	**Progress Notes[2]**
A.**Increase parent & student knowledge of Immun. requirement for school and/or Daycare attendance.**	• Educational Campaign to include flyers and posters targeting parents in the months leading up to Primary Review.	• Response to info assessed by asking how client became aware and further evidenced by the number of school, daycare exclusions.	To be completed for the FY 2006 Report	To be completed for the FY 2006 Report

[1] **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
[2] **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

Local Health Department: Morrow County
Plan B - Chosen Focus Area: ALERT Promotion
Fiscal Years 2006-2008

Year 1: July 2005 – June 2006				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results[1]**	**Progress Notes[2]**
A Increase the awareness of and subsequent use of ALERT throughout the school system.	1. Contact each of the schools and at the State level to assess the number currently using ALERT. 2. Offer information, training and/or assist-ance as needed to increase usage.	• Increase the total number of schools using ALERT based on comparison of current users.	To be completed for the FY 2006 Report	To be completed for the FY 2006 Report
B.			To be completed for the FY 2006 Report	To be completed for the FY 2006 Report

[1] **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
[2] **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

Year 2: July 2006 – June 2007				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results[1]**	**Progress Notes[2]**
A. Continue to increase the use of ALERT within the school system throughout the county.	• Follow-up contact with each of the schools regarding the use of ALERT.	• Continued increase in the number of schools utilizing ALERT compared with the previous FY.	To be completed for the FY 2007 Report	To be completed for the FY 2007 Report
B.			To be completed for the FY 2007 Report	To be completed for the FY 2007 Report

[1] **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
[2] **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

Year 3: July 2007 – June 2008				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results[1]**	**Progress Notes[2]**
A. All of the schools will be utilizing ALERT by June 2008.	• Continued communication with each of the schools to answer questions and provide needed supports to ensure success in using ALERT.	• Evidenced by the total number of schools using ALERT within the county.	To be completed for the FY 2008 Report	To be completed for the FY 2008 Report
B.			To be completed for the FY 2008 Report	To be completed for the FY 2008 Report

[1] **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
[2] **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

APPENDIX

Local Health Department: ~~Morrow County~~
Plan A - Continuous Quality Improvement: Improve Immunization Coverage
Fiscal Years 2006-2008

Year 1: July 2005 – June 2006				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results[1]**	**Progress Notes[2]**
A. Decrease percent of missed shots/opportunities.	1.Education of Staff followed by that of Parents. 2. Give ALL indicated vaccinations at time of service except when parent refuses.	• Percentage of missed shots to be decreased to 10% by next year (2005 data).	To be completed for the FY 2006 Report	To be completed for the FY 2006 Report
B. Increase percent of Hep B dose #3 by 24mos age.	1. Reminder sticker on Imm., record to reflect minimal spacing. 2. Provide client with clinic day/hours reminder card, eval ea visit. 3. Provide WIC with clinic day/hour info.	-Increase in percent of Hep B dose #3 to 82% at 24 mos of age by next year (2005 data).	To be completed for the FY 2006 Report	To be completed for the FY 2006 Report

[1] **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
[2] **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

Year 2: July 2006 – June 2007				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results[1]**	**Progress Notes[2]**
A. Decrease percent of missed shots and /or opportunities.	1. Evaluation of staff offering of all indicated vacccine at each contact. 2. Evaluation of acceptance of all indicated vaccines by parent, at time of service.	• Percentage of missed doses to be 9% or less per most recent data.	To be completed for the FY 2007 Report	To be completed for the FY 2007 Report
B. Increase percent of Hep B dose # 3 by age 24 mos.	1.Continuation of reminder sticker for minimal spacing. 2. Cont. use of clinic day/hour card, eval adeq. of vac ea visit. 3. Check with WIC regarding cont. use of reminders.	-Continue to increase percent of Hep B dose # 3 to 84%, by 24 mos of age per most recent data.	To be completed for the FY 2007 Report	To be completed for the FY 2007 Report

[1] **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
[2] **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

Year 3: July 2007 – June 2008				
Objectives	**Methods / Tasks**	**Outcome Measure(s)**	**Outcome Measure(s) Results[1]**	**Progress Notes[2]**
A. Continue to improve (decrease number) of missed doses.	1.Continue to offer all indicated vaccines at time of service. 2. Evaluate responsi-veness of parent/s re total vac offered.	• Percentage of missed opportunity as per most current data to be 8% or less.	To be completed for the FY 2008 Report	To be completed for the FY 2008 Report
B. Continue to in-crease the percent of Hep B dose # 3 received by 24 mos. of age.	1. Continue to provide reminders of next dose due at minimal spacing. 2. Cont. use of clinic cards for day/hours services available. 3.Cont. use of cards/ reminders per WIC.	-Continue to increase percentage of Hep B dose # 3 to 86%, at 24 mos of age as per most recent data.	To be completed for the FY 2008 Report	To be completed for the FY 2008 Report

[1] **Outcome Measure(s) Results** – please report on the specific Outcome Measure(s) in this table.
[2] **Progress Notes** – please include information about the successes and challenges in completing the Methods/Tasks, any information that will help us better understand your progress, and any assistance from DHS that would have helped or will help met these objectives in the future.

Oregon Dept. of Human Services
OFFICE OF FAMILY HEALTH

FY 2004-2006 ANNUAL PLAN
FOR FAMILY HEALTH PROGRAMS

Department of Human Services
Office of Family Health

MORROW COUNTY

FAMILY HEALTH
PROGRAM PLAN
2004 -2006

Submitted by:

Sheree Smith (actual signature to follow with the paper copies in the mail)
Signature, Administrator, Health Department

05/24/05
Date

Available in Alternate Format
503-731-4021

FY 2006 ANNUAL PLAN
FOR FAMILY HEALTH PROGRAMS

MORROW COUNTY
(Submitted 05/16/05)

Family Planning Program Plan

Name of Person Completing Plan: **Sheree Smith**
Phone: **(541) 676-5421** E-mail Address: **<ssmith@co.morrow.or.us>**

1. Please provide any plans you have for the upcoming fiscal year:

   - To open or close any family planning clinic sites

   There are no plans to open or close any clinic sites this next FY.

   - To add or reduce any FTE working in family planning

   There are no plans to add or reduce any FTE within the FP program.

   - To offer any new birth control methods

   We have no current plans to offer additional birth control methods but we have discussed the possibility of adding methods at a later time.

   - To contract or partner with another agency in your community to provide clinical, educational or other related services

   There are no plans at this time to contract or partner.

2. Please see the FP service data included here to review your agency's Women In Need (WIN) data and provide a plan for reaching a greater share of this population in FY 05 – 06.

   First of all, I think that it is impressive to note that we are currently serving 54.2% of the WIN population in our county, compared with the state avg. of 39.9%. The plan for reaching a greater portion of our population includes increasing the community's awareness of this available resource.

A.) <u>Increase awareness of services offered:</u>

<u>1.)</u> Continue participation at community events including Health Fairs, Children's Fair, County Fair, Etc. (as the opportunity arises within the county).

<u>2.)</u> Provide Appt. cards that list clinic schedule (days/hours).

<u>3.)</u> Contact each of the Middle and High Schools (in the county) to discuss possible (acceptable) forms of advertisement for services available (within FY 2006).

<u>4.)</u> Offer a presentation to each of the Superintendent of Schools highlighting county data as it relates to our JR/SR High school populations (within FY 2006).

<u>5.)</u> Revisit discussion with the School Superintendent/s regarding student access of services during school hours (within FY 2006).

<u>6.)</u> Create a Morrow County Public Health pamphlet highlighting services available. This pamphlet would then be shared with Primary Care providers and other community agencies for dispersal to future potential clients.

3. Please provide your plans for community education on family planning issues for the 2005 –2006 fiscal year, including how you intend to evaluate these activities.

<u>There are several activities identified above in an effort to increase community awareness and education. The plan is to offer the same presentation to the County Court, to community groups that we participate in and other groups as requested. The evaluation will be based on numbers/percentage of clients served of the (WIN) population within the Morrow County FP program compared with the current data.</u>

4. Please provide your plans for Quality Improvement in the 2005-2006 fiscal year, including how you intend to evaluate these activities.

The primary activity planned to augment quality improvement of our family planning program is creating Education Protocols to ensure the consistency of information provided to the clients.

EVALUATION of Activities: The creation of the education protocols, followed by an orientation of staff members and implementation of these protocols within FY 2006.

5. Please provide your plan for improving or increasing client education or counseling (e.g. new approaches, techniques, protocols, procedures, screening, materials), including how you intend to evaluate these activities.

The improvement is as stated above: Our plan to improve the quality and consistency of the information and education provided to each of our clients through the implementation of Education protocols.

EVALUATION: The creation of the education protocols, followed by an orientation of staff members and implementation of these protocols within FY 2006.

6. Please identify any topics or issues on which you would like additional information or technical assistance from state family planning program staff.

There are no topics or issues identified at this time. Whenever a question or concern arises we do not hesitate to contact our partners at the state. We have appreciated their support and helpfulness in assisting our local program/s in the past.

DEPARTMENT OF HUMAN SERVICES
OFFICE OF FAMILY HEALTH
FY 2006

MATERNAL AND CHILD HEALTH PROGRAM
USE OF FUNDS PLAN

DUE MAY 15, 2005

Agency Name: **Morrow County**

Date: **05/12/05**

Contact Person, Phone And Email: **Sheree Smith (541) 676-5421 <ssmith@co.morrow.or.us>**

	A	B	C	D	E
	Total MCH Fund Allocation by Program	Perinatal Health	Babies First!	Child & Adolescent Health	Total Allocation
1	Original Allocation (enter from spreadsheet)	**$ 1,822**	**$ 5,717**	**$ 22,698**	$30,237
2	Optional Re-distribution of Child & Adolescent Health Funds (not less than 30% of total CAH)	**$ 3,698**		**$19,000**	$22,698
3	**SUBTOTAL**	$ 5,520	$5,717	$19,000	$30,237
4	*If applicable*: Oregon MothersCare Allocation -	**$ 4,187**			$4,187
5	**TOTAL ALL FUNDS**	$ 9,707	$5,717	$19,000	$34,424

Redistribution total should match original allocation (cell 2E = cell 1D)

Allocation total in 3E should match original allocation in 1E

INSTRUCTIONS

To update Total automatically: Highlight the cell, or "select" whole table, and press F9.

- Enter your county MCH allocation (from attached spreadsheet) in the white boxes in Row 1.
- Enter your MothersCare allocation if are receiving those funds.
- If you wish to shift Child and Adolescent allocation into Perinatal, show that shift in Row 2; the total for this Row should be the same as the total Child and Adolescent Allocation
- On the next pages, indicate an estimate of the proportion of funds for the services listed
- Add additional comments and requests for technical assistance on the last page

For assistance on this document, contact Molly Emmons at 503-731-4313, molly.emmons@state.or.us

Return all parts of this form to:
Electronically: molly.emmons@state.or.us
Or by Fax: 503-731-4091
Or by Mail: 800 N.E. Oregon St, Suite 825, Portland, OR 97232

PERINATAL HEALTH PROGRAMS

Perinatal Program Plan and Budget

State Perinatal funds can be used for any combination of the following three services:

1. Maternity Case Management (MCM) for non-Medicaid-eligible women ($500 per client)
2. Prenatal clinical care for non-Medicaid-eligible women ($500 per client)
3. Oregon MothersCare (OMC) access services for any pregnant woman

Please complete the following table indicating how you plan to use your perinatal program funds. Include only MCH funds, not other sources of funds. The total Perinatal Program Funds in this table should be the same as the Perinatal Program Funds on the preceding page.

Type of Service	Estimated # clients to be served	Estimated Funds Allocated		
1. Maternity Case Management for non-Medicaid-eligible women	8	$ 720		
2. Clinical Prenatal Care for non-Medicaid-eligible women	6	$ 4,800	$5,520	Should match Perinatal Subtotal (without MothersCare) on p. 1
If applicable: 3. Oregon MothersCare access services for any pregnant woman	55	$4,187	$9,707	

County birth data can be found on the web at:
http://www.dhs.state.or.us/publichealth/chs/cdb.cfm

Add additional comments on page 4

CHILD AND ADOLESCENT HEALTH PROGRAMS

Child and Adolescent funds are flexible and can be shifted to Perinatal if necessary. HOWEVER, it is required by Title V that 30% of the Total MCH funds be targeted to children and adolescents. Therefore, the minimum total for both Child and Adolescent should be no less than 30 % of the total MCH Funds.

CHILD HEALTH SERVICES	Estimated Funds Allocated
1. Clinical Services	-0-
a. Well child care (non-immunizations)	-0-
b. Screening and referral (non-Babies First/Healthy Start)	-0-
2. Child Care Nurse Consultation	$50
3. Nutrition & Physical Activity (see related comments below)	$200
4. Early Hearing Detection and Intervention	$100
5. Other: Activities to be funded: High Risk Infant tracking (non-OHP elig.), limited oral health education and referral, general safety education and health promotion, Parent Education, Growth & Development info with suggested age approp. activities, Breastfeeding support and education (including nutrition info for MOB), referral to Food and Nutrition resources, etc.	$3,500
SUBTOTAL	$3,850

ADOLESCENT HEALTH SERVICES	Estimated Funds Allocated
1.School Health Services	-0-
a. School Nursing	-0-
b. Coordinated School Health	-0-
c. School -Based Health Centers	-0-
2.Teen Pregnancy Prevention/Contraceptive Access	$8400
3.Youth Suicide Prevention	-0-
4.Tobacco Use Prevention & Cessation	$200
5.Alcohol and Other Drug Use Prevention	$500
6.Nutrition & Physical Activity	$450
7. Other: Immunization	$5,500
SUBTOTAL	**$ 15,150**

CHILD AND ADOLESCENT HEALTH TOTAL FUNDS	**$19,000**
Should match Child/Adolescent Funds Total on Page 1	**$19,000**

Add additional comments on page 4

Please add additional comments, information or request technical assistance for MCH programs:

(See below the amended portion of III Action Plan, already submitted for FY 2006)

1. **Parent and Child Health (OAR 333-014-0050 (2) (b)).**

A. Current Conditions or Problem. In this past year we have been able to increase the FTE (by a few hours) of two of the nursing positions. One of the positions went from 0.8 to 1.0 FTE and the other position was increased from 0.49 to 0.8 FTE. Of these increased hours, a portion will be to increase hours in home visiting (MCM, Babies First, CaCoon and Healthy Start). The other increase in hours will be within OMC and the BCC program.

***B.* Goals.** The goal to increase nursing hours has been partially met (it is not by a full 1.0 FTE as was the goal). The next goal will be to actually have come to now appreciate an increase in the services we are able to provide within the home visiting program.

C. Activities. We have been able to show increased revenues in MAC billing as well as fee for services. We are also planning on having an increase in funds with a limited number of TCM visits.

D. Evaluation. This will be based on the addition of home visiting services offered.

Perinatal Health Programs:

We currently receive a program specific grant for OMC and we are currently focusing on making improvements on the delivery of OMC services. With the increased FTE noted above, we hope to increase services offered and increase activities related to perinatal health including MCM services.

Child Health Programs:

As related to homevisiting services (Babies First and Cacoon): we have had a small amount of increased FTE at noted above and our intention is that this will result in an increase in services provided, a portion of which will be TCM services. Also included in this area is child safety. We continue to have three Certified Carseat Technicians providing the dispersal of seats and one-to-one instruction/education and assistance with hands on training of carseat installation.

Other related Child Health Programs as identified for Child and Adolescent re-distribution of funds: High Risk Infant tracking (non-OHP elig.), limited oral health education and referral, general safety education and health promotion, Parent Education, Growth & Development info with suggested age approp. activities, Breastfeeding support and education (including nutrition info for MOB), referral to Food and Nutrition resources, etc.

Adolescent Health Programs:

Prevention of teen pregnancies continues to be a primary focus for Public Health. Activities provided include education and access to needed services and supplies. One of the barriers that we have encountered is regarding access of services (primarily family planning), during school hours. The student may have transportation or other privacy issues which make it impossible to access care outside of school hours. Previously the school had accepted a note (which included info that they had been at the clinic only) so that the absence was "excused". The school no longer honors the previous verbal agreement based on school district Policy allowing notes for excused absences to be submitted by parents only. This is a bit of a barrier but the clinic is open during the scheduled lunch period/s and the nurses try to be sensitive to this issue, taking the client in and providing the service as quickly as possible. For some of the students (where transportation or accountability is not as issue) it has not been a problem to come to clinic after school hours.

Included in the Family Health Plan are activities targeting these current barriers to family planning and other public health services. The activities identified in the Plan include: offering a presentation to each of the Superintendent of Schools highlighting county data as it relates to our JR/SR High school populations; and to revisit discussion with the School Superintendent/s regarding student access of services during school hours.

Other areas related to Adolescent Health are the promotion of health through assessment and education as well as the provision of applicable services. Included areas of focus are: Immunization; Tobacco, Alcohol and Drug use prevention (and referral as appropriate); nutrition; physical activity; oral health; and safety (including injury prevention).

Other Needs or Comments:

There are no other needs identified at this time.

BCC and Komen Program
Progress Report*

Local program **Morrow County Health Dept.**

Contact person **Sheree Smith Public Health Director**

Date submitted **05/01/05**

I. **Dates:** July 1, 2004 – To Present
Due to DHS: **May 1, 2005**

II. **Progress toward objectives:** Please describe program activities over the past six months for the program areas listed below. Refer to specific objectives in your Annual Program Plan, as relevant. Note: Local programs that receive education funds only should complete all sections of this report except Section II 2 and 3. Please check the sections included in your report.

__ 1. **General Program Management** (e.g. staff, provider network, acceptable and accessible program services, communication with providers, fiscal management, data collection, submit required reports, percent of services in a primary care setting and progress toward screening goal)

The staffing level continues to be adequate for our numbers of clients. There was a change in the BCC coordinator this past year which could have had a negative impact on the program. Thankfully this was not the case as our new coordinator (Kelly Holland) has worked very hard to maintain the relationships forged with the providers as well as other community contacts. Communication with providers this past year has continued and remains an ongoing process. This has been accomplished in a variety of ways. These have included phone contacts, one on one contact both with the PCP's and their support staff and the provision of program support materials and information. The number of providers continues to be somewhat limited, but Kelly has worked very hard to increase provider participation as well. Due to her efforts we also have continued cooperation in addition to a good understanding of available services.

Kelly has worked very hard to meet our 2004 – 2005 goals. We have continued efforts to reach the 50 – 64 age group, but we still have 4 available slots for this year. Our numbers of clients served in FY 2005 are currently: Komen only – 3 (with permission granted to increase from the original goal of 2); BCC/Komen – 9; and BCC - 7.

The Fiscal management has shown some improvement with a system to identify the participants as BCC vs Komen. It can still be confusing at times but the process has become a bit easier.

Documentation, collection of data and submission of reports is being submitted in a timely manner. Monthly data tallies have also

shown improvement. This was a bit of a struggle initially with the change over in staff but the monthly tallies are now being submitted on or before the 15th of each month.

We continue to have a good relationship with DHS/BCC staff and we make contact frequently as questions arise or if there is needed clarification. The DHS staff continues to be accessible, supportive, knowledgeable and they are always kind when we have been in need of their help. This is something that we as a small program have valued and truly appreciated in our efforts to provide this service locally.

__ 2. **Recruitment of Priority Populations** (e.g. demographics of women screened, identify priority populations, conduct recruitment activities using a variety of media and education strategies, monitor referral sources, conduct culturally appropriate activities and deliver culturally appropriate recruitment messages, percentage age 50-64, rescreening, and rarely/never screened)

We have continued our efforts to stay in close contact with our priority population recruiting through our clinic contacts and our Lay Health Promoters. We continue to make it a practice to send out letters inviting all clients served the previous year (particularly those ages 50 – 64) to return for rescreening. To date, Kelly has sent twenty – four letters this FY and has also made some follow up phone calls additionally. We have had a small number of letters returned as clients no longer lived at the address listed.

It continues to be a struggle to reach the 50 - 64 year age group. The 40 - 49 age group is still the age group seen most often within our clinic and is often the age of outside referrals. Within our clinics, I believe that it is due to the services they are seeking (i.e. FP services, immunizations for their children, etc.). Although this has frequently been the age group most likely to be referred by our health care partners, there has been some improvement shown based on Kelly's efforts to better inform and educate them. We continue efforts to access the older age group among our Hispanic culture through the education of younger women and through their own familial relationships both within the clinic setting and the community. There are times that the 50-64 age group have accompanied family members to the clinic and we try to take that opportunity to assess their need as well as their awareness of available resources.

Follow up contact efforts are ongoing with the use of a log type format of documentation. This helps in assuring that follow through of appointments and any other related services are being accessed appropriately. If services are not accessed, the log identifies possible problems or barriers to service and provides an opportunity to make adjustments in planning as needed to assure availability of care. The client is contacted by phone, a letter or other method as appropriate for that particular client.

__ 3. **Screening Services** (e.g. eligibility and special needs assessment, delivery of complete, timely and clinically appropriate services, use of tracking and follow-up systems, provision of case management services)

We continue to use a system for enrolling clients and scheduling appointments that allow us to be aware of appointment times and scheduling. This makes follow up and collection of information easier to access; although timeliness is still most often dependent upon the provider and remains at times a frustration. In particular, outreach to the PCP's has shown an improvement in the timeliness of result notification. There is currently only one provider that continues to be somewhat slow in the documentation process, consequently the supporting staff are unable to access this information any quicker. We have attempted to address this issue primarily with education of the process. Currently efforts are made to request results in a consistent, kind, non-threatening, respectful manner. Program screening protocols are followed as per the BCC program guidelines with reference to the DHS/BCC staff if questions arise.

Our relationship with the providers remains good. As identified elsewhere, we continue to encourage them re the need for timeliness of results of screening; especially of abnormal results. Providers are also advised of any changes made to the BCC program that have any relevancy to them and the care they provide.

Case Management: All clients with abnormal results are assisted in obtaining any needed follow up testing and/or services in a timely manner. As we know from past experience, this works well when the client is compliant and has challenges all its own when they are not. Written case management plans are in place for clients with abnormal findings.

__ 4. **Community Education and Community Collaborator Activities** (e.g. use of demographic data and community feedback, collaboration with community partners to conduct education activities, evaluation of education activities, and communication mechanisms with community partners)

There is no system in place for any type of formal inquiry/survey, re client/community feedback as of this time. This may be something that we choose to implement in the future. The employees of the Health Department are all active members of the community and involved in several aspects that affect education, health services and community affairs having an impact on the population. I believe that this gives us insight into our communities that is both unusual and unique to small rural areas. As a whole, we are fairly well informed of local demographics and community needs.

The BCC coordinator keeps providers current on BCC protocols and provides updates regarding any program changes. She also provides support materials and information for the education of both providers and clients.

We do not have any education activities or coalition groups in progress in our county. We continue to educate women on women's health topics/issues in our clinics.

III. **Requests to DHS staff:** Please note any technical assistance or other need.

Two of our local staff members (Kelly and Marilyn) have recently accessed training on both coding and the new software program. I believe that this will be very helpful in our ongoing efforts to provide services within our county. Otherwise, I do not have any specific training requests of the DHS staff at this time. We continue to appreciate the support and assistance available and given by all of the DHS BCC staff. You have all been most helpful to us and I would like to thank you for your efforts.

IV. **Appendix:** Include a copy of any written material that demonstrates your program's work during this period (e.g. newsletters, articles, communication with providers, sample forms).

* Defined in the BCC Program Element

Oregon Breast & Cervical Cancer Program
Komen Breast Screening Program

Date 04/021/05 **Local health department/tribe** Morrow County Health Dept.

Contact person: **Sheree Smith Public Health Director**

Phone number: **(541) 676-5421** Fax: **(541) 676-5652**

Sections of the plan to be completed (check those included in your Plan):

_X_ Part A. **Narrative review and evaluation of the past year**, based on the objectives in your Annual Plan (July 1, 2004 - June 30, 2005).

_X_ Part B. **Annual Program Self-Assessment** - completed and included.

_X_ Part C. **Annual Program Improvement Plan** - Objectives and strategies in your Plan should be based on the priorities you set for the next year (July 1, 2005 – June 30, 2006) after completing the Self-Assessment tool. Please check all sections that are included in your Plan:

_X_ I. **General Program Management**

_X_ II. **Recruitment of Priority Populations**

_X_ III. **Screening Services**

_X_ IV **Community Education and Community Collaborator Activities**

Annual Plan FY 2006* (July 1, 2005 – June 30, 2006)

The Annual Program Plan document has been revised and is now an "Annual Program Improvement Plan". The new Plan is aligned with Program Element documents that are currently going through an approval process. Please refer to the current fiscal year's Program Element in the interim. A copy of these Annual Plan materials is being sent to Administrators and BCC Program Coordinators at each local health department and tribal program.

Please include one copy of your Annual Program Improvement Plan with your county or tribe Grant Application Packet to DHS Health Services (due May 1, 2005). Also submit this cover page, your Narrative, your Self-Assessment and your Plan to:

Sharon Washington-Clark, MSHA
Program Manager

Oregon Breast & Cervical Cancer Program
800 NE Oregon Street, Suite 730
Portland, OR 97232

If these documents are not received by May 1st, BCC and Komen Program funds cannot be guaranteed by July 1, 2005. Please call Sharon Washington-Clark at (503) 731-4332 if you have questions.

Oregon Breast & Cervical Cancer and Komen Programs **Organization: Morrow County Health Dept.**
Annual Program Improvement Plan: July 1, 2005- June 30, 2006 **Program Staff: Sheree Smith, RN/Kelly Holland, RN**

1. General Program Management

Perform program management functions, including meeting requirements in the following areas: staffing and contracting, provider networks, fiscal management, record keeping, data collection, and reporting. Maintain communication with internal and external partners regarding the Program.

A. Maintain adequate staff (program coordinator, community educator, case manager and clinical consultation) and resources for the Program.
B. Develop and maintain a network of Screening Service Providers to provide Screening Services in the Service Area in a timely manner.
C. The Program must be accessible, acceptable and available to the community and meet the needs of medically underserved individuals in the Service Area.
D. Maintain communication with DHS staff, Screening Service Providers and other Program staff.
E. Maintain a fiscal management system to assure appropriate use of funds.
F. Collect Minimum Data Elements, clinical reports and documentation relating to Screening Services delivery and maintain medical records.
G. Deliver at least 75% of Screening Services in a primary care setting.
H. Meet annual Screening Goals (at least 90%) for the BCC and Komen Awards.
I. Submit required reports and other documentation that are complete and on time.

Objectives	Activities Planned to Meet Objectives	**Who Is Responsible** (Local Program and/or Community Collaborators)	Evaluation/Outcome (Measures of Success)

A. Maintain adequate staff (pro-gram coordinator, community educator, case manager and clini-cal consultation) and resources for the Program.	A. Adequate staff in place at this time.	A. N/A at this time.	A. N/A at this time.
B. Develop and maintain a net-work of Screening Service Providers to provide Screening Services in the Service Area in a timely manner.	B. Provider network is in place, N/A.	B. N/A at this time.	B. N/A at this time.
C. The Program must be access-ible, acceptable and available to the community and meet the needs of medically underserved individuals in the Service Area.	C. Continue to collaborate with community members and provide education within the clinic setting as well as to various groups within the community regarding the necessity and availability of services.	C. Kelly, Sheree and other staff members involved with the BCC program as appropriate.	C. Evaluated as per the clients that are accessing care.
D. Maintain communication with DHS staff, Screening Service Providers and other Program staff	D. DHS staff to be contacted anytime there is a ques-tion that arises or we are in need of some other type of help or assistance.	D. Kelly, Sheree or Marilyn.	D. Not a problem at this time as anytime we need assistance, we are making contact with DHS.
E. Maintain a fiscal management system to assure appropriate use of funds.	E. Continue to track expenditures in an efficient and accurate manner.	E. Sheree& Marilyn Primarily.	E. Revenue and expenditure reports to reflect appropri-ate use of BCC funds.
F. Collect Minimum Data Ele-ments, clinical reports and docu-mentation relating to Screening Services delivery and maintain medical records.	F. Continue to collect and document data elements.	F. Kelly	F. Ongoing collection of data elements, reports and documentation.
G. Deliver at least 75% of Screening Services in a primary care setting.	G. Services continued to be offered primarily in a primary care setting.	G. Kelly	
	H. Annual goals to be appropriate for Morrow	H. Kelly/Sheree	

H. Meet annual Screening Goals (at least 90%) for the BCC and Komen Awards. --- I. Submit required reports, plans and other documentation as required, completed and on time.	County population. We have increased our recruitment activity as reported in the self-assessment tool. --- I. Documentation of needed data ongoing. Gathering of necessary info initiated in a timely fashion so that reports and other documents are completed within the allotted timeframes.	I. Sheree/Kelly	G. Services to continue to be offered in a primary care setting 75% or more. --- H. Evaluation will be based on BCC Program goals in comparison with the actual number of clients served. --- I. Evaluation based on time-liness of submission of all requested reports and other data to DHS.

II. Recruitment of Priority Populations

Recruit individuals with low incomes who are medically underserved and are not currently accessing health services, and encourage them to return for re-screening at recommended intervals. Priority populations are women ages 50–64, women of color, women who live in rural areas, women with disabilities, and lesbians; all of whom may be at risk of not getting screened.

A. Review program data provided by the Department to determine demographics of individuals receiving Screening Services.
B. Identify the Priority Populations for program services on an annual basis for the Service Area.
C. Involve Priority Populations in planning and implementing recruitment activities.
D. Conduct recruitment activities to reach Priority Populations using a variety of media and education strategies.
E. Monitor enrollment information to determine referral sources and effectiveness of recruitment activities.
F. Collaborate with community organizations with direct access to Priority Populations to define and conduct culturally appropriate recruitment activities.
G. Develop and deliver recruitment messages that are consistent with recruitment priorities.
H. Increase the percentage of women receiving BCC Screening Services who are age 50-64 (goal is 75%).
I. Increase the percentage of women re-screened, with a focus on age 50-64 (goal is at least 50% of each prior year's breast Screening Services with normal results).
J. Increase the percentage of women served who have a history of being rarely or never screened for cervical cancer (goal is at least 20% of initial cervical Screening Services).

	Activities Planned to Meet Objectives	Who Is Responsible (Local Program and/or Community Collaborators)	Evaluation/Outcomes (Measures of Success)
A. Review program data provid-ed by the Department to deter-mine demographics of individu-als receiving Screening Services. **B. Identify the Priority Population for program services on an annual basis for the Service Area.** **C. Involve Priority Populations in planning and implementing recruitment activities.** **D. Conduct recruitment activities to reach Priority Populations using a variety of**	**A. We will review the data regarding the demographics of those clients served within the program. In this way we can evaluate specifically the age, ethnicity and area where clients reside to identify areas of weakness and thus develop a plan to improve outreach.** **B. Actively target eligible persons of the desired age groups, particularly 50-64 y/o. Ongoing communication with PCP's making referrals, education/referrals to clients coming in for other services and/or with other family members and outreach to community groups.** **C. Outreach to other community members to help identify persons within the priority population i.e. the SR center, neighborhood center, community groups, etc.** **D. Continue the use of TV media, placement of**	**A. Kelly/Sheree** **B. Kelly and other staff members involved in providing services.** **C. Kelly** **D. Kelly**	**A. Evaluation would be reflective of the demographics of those served (met/unmet) goal numbers for each group.** **B. Evaluation of clients served within the priority group, those aged 50-64 years.** **C. Community outreach done and identification of priority pop-ulations not previously contacted.** **D. Were the activities done and also asking new recruits**

media and education strategies. E. Monitor enrollment information to determine referral sources and effectiveness of recruitment activities. --- F. Collaborate with community organizations with direct access to Priority Populations to define and conduct culturally appropriate recruitment activities --- G. Develop and deliver recruit- ment messages that are consi-stent with recruitment priorities. --- H. Increase the percentage of women receiving BCC Screening Services who age 50-64 (goal is 75%). --- I. Increase the percentage of wo-men re-screened, with a focus on age 50-64 (goal is at least 50% of the prior year's breast Screen-ing Services with normal results). --- J. Increase the percentage of women served with history of being rarely/ never screened for cervical cancer (goal at least 20% of initial cervical Screening Services).	program material in strategic locations, outreach to the PCP's and their support staff to increase their awareness and knowledge of the BCC program as a resource. E. Asking and documenting the referral source of new recruits. We want to ask how they became aware of this resource to identify those activities that were most effective. --- F. Continue outreach activities to community organizations providing culturally appropriate information and materials. --- G. Continue promoting messages of program availabil-ity with consideration of the cultural demographics and with an emphasis on the 50-64 year age group. --- H. Continue outreach efforts to this specific age group (50-64) through LHD clinics, various community events, clubs, etc. We continue to focus on increasing the number of clients served within this age group. --- I. Continue to maintain demographic info on each client to enable follow up including reminder letters and/or phone calls to encourage clients to return. --- J. Continue outreach activities within the health department and the community.	E. Kelly --- F. Kelly --- G. Kelly --- H. Kelly/ Sheree and other support staff. --- I. Kelly --- J. Kelly and other staff involved in the delivery of services.	how they became aware of the program to evaluate activity effectiveness. E. Using this info to evaluate activities that were most helpful, in our efforts to increase community awareness. --- F. Activities conducted as planned. --- G. Are recruitment messages cul-turally appropriate as well as directed at the 50-64 priority group. --- H. Evaluation to be based on the percentage of clients 50 – 64 served in comparison with the previous year/ years. --- I. Clients served in the current year to be reflective of previously served clients. Evaluation based on percentage of clients return-ing for repeat services. --- J. Evaluated as a direct number of new clients into the program with limited/ no history of previous screening.

III. Screening Services

Conduct enrollment activities, deliver complete, timely and clinically appropriate Screening Services, maintain Tracking and Follow-up Systems, and provide Case Management for clients with abnormal screening test results.

A. Maintain a system to assess eligibility and special needs and to schedule appointments.
B. Assure that Screening Services are complete, timely and clinically appropriate, according to program guidelines and protocols.
C. Establish and utilize Tracking and Follow-up Systems to assure timely and complete services.
D. Provide Case Management services to all individuals with abnormal screening or diagnostic test results.
E. Assure that all mammograms are conducted in facilities that meet the Mammography Quality Standards Act (MQSA) certification.
F. Assure that all cytology services are delivered in facilities that meet the standards and regulations for the Clinical Laboratory Improvement Act (CLIA).
G. Ensure that a final diagnosis is made for at least 90% of all Screening Services with an abnormal test result.
H. Ensure that less than 10% of all individuals with abnormal test results refuse further Screening Services or are lost to follow up.

Objectives	Activities Planned to Meet Objectives	Who Is Responsible (Local Program and/or Community Collaborators)	Evaluation/Outcomes (Measures of Success)
A. Maintain a system to assess eligibility and special needs and to schedule appointments.	**A. Address special needs during the enrollment period and document on the client record.**	**A. Kelly**	**A. Sensitivity to special needs evi-denced by client F/U of appoint-ment/s and utilization of services.**
B. Assure that Screening Ser-vices are complete, timely and clinically appropriate, according to program guidelines and protocols.	**B. Follow up with PCP regarding services received to ensure acquisition. If additional care or follow up is needed this may include contact with the PCP or BCC program staff to verify appropriate and adequate care is rendered.**	**B. Kelly**	**B. Clients to receive adequate and appropriate care.**
C. Establish and utilize tracking and follow-up systems to assure timely and complete services.	**C. Continue to maintain established relationships with the PCP's with an emphasis on the importance of timely follow-up and the submission of results within the designated time frames (requires ongoing monitoring).**	**C. BCC providers and Kelly.**	**C. Evaluation would be based on the length of time from the date of screening to the date of result notification.**
D. Provide case management services to all individuals with abnormal screening or diag-nostic test results.	**D. Continue to complete assessments for clients that have abnormal results with written plans that are monitored and updated as needed.**	**D. Kelly**	**D. Evaluation reflective of ade-quacy of assessments and plans, with the resolution of cases.**
E. Assure that all mammo-	**E. Continue to utilize the services of facilities that meet the MQSA certification.**	**E. Kelly/Sheree**	

grams are conducted in facilities that meet the Mammography Quality Standards Act (MQSA) certification. F. Assure that all cytology services are delivered in facilities that meet the standards and regulations for the Clinical Laboratory Improvement Act (CLIA). _____ G. Ensure that a final diagnosis is made for at least 90% of all Screening Services with an ab-normal test result. _____ H. Ensure that less than 10% of all individuals with abnormal test results refuse further Screening Services or are lost to follow up.	F. Continue to utilize the services of facilities that meet the standards and regulations of CLIA. _____ G. Continue to monitor abnormal results to assure that a final diagnosis is completed with appropriate care prescribed and accessed. _____ H. Continue current efforts to follow up with clients following an abnormal test result through TC's and letters (including certified letters) as well as other routes as appropriate to each client. Consultation with BCC DHS staff may take place as well.	F. Kelly/Sheree _____ G. Kelly _____ H. Kelly	E. All facilities utilized for services to clients continue to be MQSA certified. F. All facilities utilized for services to clients continue to meet CLIA standards and regulations. G. Based on the number of clients receiving a final diagnosis with resolution of care following an abnormal test result. _____ H. Clients lost to follow up after an abnormal test result to continue to be less than 10%.

IV. Community Education and Community Collaborator Activities

Establish and maintain collaborative relationships with health care providers, community organizations and individuals who participate in the promotion of early detection education and screening activities and have contact with the priority populations in the service area. Through the Program, these relationships can reduce duplication of effort, expand networks and combine resources for maximum benefit to increase screening among all Oregonians.

A. Analyze demographic data and community feedback from the Service Area to determine education priorities.
B. Coordinate with Community Collaborators to conduct education activities to promote early detection of breast and cervical cancer.
C. Evaluate education activities to determine effectiveness and outcomes to enhance decision-making about future use of limited resources.
D. Develop and maintain mechanisms to communicate with Community Collaborators on a regular basis.

Objectives	Activities Planned to Meet Objectives	Who Is Responsible (Local Program and/or Community Collaborators)	Evaluation/Outcomes (Measures of Success)
A. Analyze demographic data and community feedback from the Service Area to determine education priorities.	**A. At this time I believe that we are fairly aware of the demographics of our clientele and of our county. Although we do not have a formal way of analyzing demographic data, we do try to take this info into account. However, we may consider some avenue for community feedback in the future. No planned activities at this time.**	**A. N/A**	**A. N/A**
B. Coordinate with Community Collaborators to conduct education activities to promote early detection of breast and cervical cancer.	**B. Continued information sharing and guidance (as appropriate) to BCC providers in addition to continued community outreach activities as described previously.**	**B. Kelly**	**B. Evidenced by continued involvement of the current pro-viders and continued delivery of appropriate services to community members.**
C. Evaluate education activities to determine effectiveness and outcomes to enhance decision making about future use of limited resources.	**C. Continue to assess how each BCC client became aware of the services to better evaluate the most effect-ive way to promote BCC awareness and knowledge of available resources.**	**C. Kelly**	**C. Ongoing responsiveness to the feedback obtained regarding the effectiveness of outreach efforts.**
D. Develop and maintain	**D. Continued contact with providers and other community partners to address any concerns, questions or problems in utilizing the program. This**	**D. Kelly**	**D. Continued involvement of community partners and the ongoing success of the**

mechanisms to communicate with Community Collaborators on a regular basis.	**will also include bringing new information and keeping them up to date regarding any changes within the BCC program.**		**program.**

BCC and Komen Programs
Annual Program Self-Assessment

Program: Morrow County Health Dept. **Contact:** Sheree Smith **Date:** 04/21/05

Fiscal Year: 2006

This self-assessment is a planning tool to assist programs in determining areas of strength and areas with room for improvement. This tool outlines the key program components: General Program Management, Recruitment of Priority Populations, Screening Services, Community Education and Community Collaborator Activities, Performance Goals and Reporting Requirements. Responses in this self-assessment tool can highlight program priorities for the next fiscal year.

I. General Program Management

	YES	NO	Needs Revision	Comments
A. Assign adequate staff and resources to administer the Program.				
1. Program has a coordinator, community educator and case manager.	X	☐	☐	
2. Adequate Clinical Consultation is available.	X	☐	☐	
3. Adequate management and supervision are provided to staff.	X	☐	☐	
4. Staff is able to perform work applying the Clinical Protocols.	X	☐	☐	
B. Develop and maintain a Screening Services Provider network.				
1. Services are accessible, acceptable and available to the community, and meet the needs of Priority Populations.	X	☐	☐	
2. Communication system in place to notify providers of Program updates including new CPT codes, annual income eligibility, current Medicare rates and Clinical Protocols.	X	☐	☐	
C. Utilize a fiscal management system.				
1. Funds are used appropriately, according to the Program Element.	X	☐	☐	
2. Invoices are reviewed to verify eligibility, clinical appropriateness of services, allowable services, and payment rate.	X	☐	☐	
3. Timely payment is issued to providers after verification.	X	☐	☐	
4. Quarterly Revenue and Expenditure reports are submitted.	X	☐	☐	
5. Costs are tracked to determine if per client allotments are exceeded.	X	☐	☐	

	YES	NO	Needs Revision	Comments
D. Collect the Minimum Data Elements, clinical reports and documentation relating to Screening Services delivery.				
1. A medical record is created and maintained for each individual receiving Screening Services, according to the Program Element.	X	☐	☐	_____
2. All medical records, data, and correspondence are retained, maintained and stored according to State and Federal confidentiality standards.	X	☐	☐	_____

II. Recruitment of Priority Populations

A. Recruit eligible individuals with low incomes who are medically underserved and are not currently accessing health services.				
1. Program data and reports are reviewed to determine the demographics of individuals receiving Screening Services.	X	☐	☐	_____
2. Priority Populations are identified.	X	☐	☐	_____
3. Priority Populations are involved in planning and implementing recruitment activities.	X	☐	☐	
Bilingual/Bicultural staff are included/involved in the implementation of services and community outreach.				
4. Recruitment activities are conducted using a variety of media, educational strategies, small group and one-on-one activities.	X	☐	☐	
Monthly calendars are mailed out and also printed in the local papers. Posters displayed in both Eng/Sp at strategic locations, advertisements placed on the local TV Channel, presentations were made to several local community entities and there have been several one-on-one encounters to prospective clients, to PCP's and their staff.				
5. Information on enrollment forms is monitored to determine referral sources and effectiveness of recruitment activities.	X	☐	☐	**Data forms are filled out.**
6. Program collaborates with health care providers & community organizations to define and conduct culturally appropriate recruitment activities.	X	☐	☐	
Visits have been made to each provider/clinic in the county and info presented to the PCP and/or their staff.				
7. Program develops & delivers recruitment messages that are consistent with recruitment priorities and conducts activities that are culturally appropriate.	X	☐	☐	**Displays & info in Eng/Sp.**

	YES	NO	Needs Revision	Comments
III. Screening Services				
A. All individuals seeking services must be assessed for eligibility.				
1. Age, income and insurance status are assessed.	X	☐	☐	
2. Special needs are identified (transportation, language, adaptive equipment).	X	☐	☐	
3. Appropriate clinical appointments are scheduled.	X	☐	☐	
B. All Screening Services must be delivered in a complete, timely, and clinically appropriate manner, according to the Program Manuals and Clinical Protocols.				
1. Screening Services are completed within 60 days of 1st clinical contact.	X	☐	☐	
2. Abnormal test results are obtained from Providers within 7 days. **This is true most of the time. We have one provider who is slow to complete dictation and thus follow up.**	X	☐	☐	
3. Normal test results are obtained from Providers within 30 days.	X	☐	☐	**As stated above.**
4. Individuals with abnormal test results are notified within 7 days. **If info available and/or PCP has not already done the follow up.**	X	☐	☐	
5. Individuals with normal test results are notified within 30 days. **Although this is usually done through the provider**.	X	☐	☐	
6. Information on referrals is obtained from Providers within 7 days. **Although once this year the provider decided to re-access the program and we were notified "after the fact".**	X	☐	☐	
7. Individuals with a diagnosis of cancer or pre-cancerous cervical condition are referred for treatment through BCCM or other resources within 60 days of diagnosis. **We had one client that the PCP had consulted directly and then referred for F/U care. We have been unable to contact the client in spite of numerous TC's, then a letter was sent, next a certified letter sent with no response. This was a carry over from last year.**	☐	X	☐	
8. Cases identified by DHS Follow-up are resolved within 60 days.	☐	X	☐	**(As above)**
9. Case Management needs are assessed for all individuals with an abnormal test result.	X	☐	☐	

	YES	NO	Needs Revision	Comments
C. Establish and utilize Tracking and Follow-up Systems to verify that Screening Services are delivered in a timely and complete manner.				
1. Each individual's status is tracked at all times.	X	☐	☐	
2. Clinical appropriateness of each individual's Screening Services is determined.	X	☐	☐	
3. Previously screened women are contacted for re-screening. **We continue to send out reminder letters (24 this year to date) as well as telephone follow ups.**	X	☐	☐	
D. Provide Case Management (CM) services to all individuals whose Screening Services test results are abnormal.				
1. CM services are based on a comprehensive assessment of the individual's needs and provided in accordance with a written CM plan.	X	☐	☐	
E. Mammograms are performed in facilities meeting the Mammography Quality Standard Act (MQSA) certification.	X	☐	☐	
F. Cytology services are performed in facilities meeting the Clinical Laboratory Improvement Act (CLIA) certification and using The Bethesda-III System.	X	☐	☐	

IV. Community Education and Community Collaborator Activities

A. Demographic data and community feedback are analyzed to determine education priorities. **Demographic data only.**	X	☐	☐	
B. Program works with Community Collaborators to conduct education activities.	☐	X	☐	
C. Education activities are evaluated to determine effectiveness and outcomes and enhance decision-making about future use of limited resources.	☐	X	☐	**N/A**
D. Mechanisms for regular communication with Community Collaborators are developed and maintained.	☐	X	☐	**N/A**

Oregon Breast & Cervical Cancer Program

BCC and Komen Programs
Annual Program Self-Assessment

	YES	NO	Needs Revision	Comments
V. Performance Goals				
A. Program Management				
1. At least 75% of Screening Services are provided in a primary care setting.	X	☐	☐	
2. At least 90% of the BCC and Komen Screening Goals are achieved.	X	☐	☐	
We have not yet fully met the goal this year. We are still in need of 4 more BCC (50 – 64). We currently have : BCC – 7, BCC/Komen – 9 and Komen Only – 3 (we asked and were allowed to increase our "Komen only" number by one). We continue to make every effort to target the 50 – 64 y/o age group.				
B. Recruitment				
1. At least 75% of BCC Screening Services are provided to women age 50-64. **See comments above.**	☐	X	☐	
2. At least 50% of women receiving a normal breast Screening Service in the prior year are re-screened.	X	☐	☐	
3. At least 20% of initial cervical Screening Services are provided to women who have been rarely or never screened.	X	☐	☐	
C. Service Delivery				
1. At least 90% of all Screening Services with abnormal results are complete.	X	☐	☐	
2. Less than 10% of all individuals with abnormal test results refuse further Screening Services or are lost to follow up. Documentation included in medical records.	X	☐	☐	
VI. Reporting Requirements				
A. Annual Work Plan is submitted no later than May 1st.	X	☐	☐	
B. Six-month progress report is submitted each January 20th.	X	☐	☐	
C. Annual System for Technical Assistance Reporting (STAR) report completed.	X	☐	☐	
D. Monthly Tally form is submitted no later than the 15th of each month. **Although we struggled a little for the first few months, the timeliness of tally form submission has been much improved and currently are being submitted by the 15th of the month.**	X	☐	☐	
E. Data forms are submitted within 60 days of the start of Screening Services.	X	☐	☐	