

Morrow County LPHA FY 09 Annual Plan

I. EXECUTIVE SUMMARY

Morrow County is a small rural county located in eastern Oregon with a current population of 12,125. The county is bordered by the Columbia River to the north, Umatilla County to the east, Wheeler and Grant County to the south and Gilliam County to the west. The primary industries are agriculture, food processing, dairy, energy production and tourism. The County Public Health Department provides a variety of services to the public as mandated by the Oregon State DHS Public Health Program including immunizations for all ages, family planning, maternal child health programs and supports (including homevisiting), epidemiology and control of preventable diseases, health education information and referral as appropriate. The LHD is the only provider of routine childhood immunizations in county with providers offering only limited adult vaccinations. Each year there is also a robust Influenza program offered typically from October to February. Influenza clinics are offered each year at the four major areas of populous throughout the county including each of the Senior Citizen Centers. These special clinics offer expanded clinic hours to encourage access to services and the vaccine continues to be offered at every regular clinic throughout the entire influenza season unless supplies are depleted. The LHD is relatively small in comparison to many other counties thus staff often works within many different programs. There is a significant number of Hispanics within our population making it particularly important to provide translation and educational supports in Spanish. Medical care available within the county is limited to three medical clinics (one is an FQHC and none provide prenatal services) and a 10 bed county hospital making adequate health care and maintenance a challenge. The hospital does not offer delivery services thus forcing individuals to travel to neighboring counties or into Washington State to access Prenatal Care and delivery services further challenging the ability to access early and/or adequate prenatal care. The Oregon Progress Board 2007 County Data Snapshot identifies some areas of concern, the most significant of which follows: 34th in 8th Grade Math, 35th in High School completion, 36th in College Completion, 35th in Prenatal Care, 36th in Child Care Availability and 34th in Person Crimes. The LHD actively participated in the Comprehensive Plan formulation and many of these issues were discussed during that time. The Comprehensive Plan Selected Focus Issues include: Substance Abuse, Child Care Availability, Teen Alcohol and Teen Drug Use, Gang Presence/Activities and Bullying.

Morrow County LPHA FY 09 Annual Plan

II. ASSESSMENT

ASSESSMENT UPDATE: The two assessment areas noted to have significant changes are listed below:

- 1.) **Communicable Disease:** Morrow County now has a full time staff member with shared responsibilities as a Community Health Educator and CD Coordinator. The former CD nurse continues to be closely involved with the investigation and follow-up of CD cases both as a mentor and as a resource. The other clinic nurses continue to assist with the treatment and follow-up if the disease was identified as a result of services received per Morrow County Health Dept.
- 2.) **Tobacco:** Morrow County was awarded a grant in January 2008 with funding for an 18 mos time period (Jan 2008 – June 2009). This grant included a provision for staffing at .5 FTE and additional funds were utilized to increase the position to full time. This position combines responsibilities for Community Health Education as well as CD Coordinator and was filled in the latter part of March. With the addition of this staff, a primary area of focus will be education particularly related to tobacco usage. Education can be addressed individually or at the community level, taking proactive steps in anticipation of new SmokeFree Workplace Laws effective January 2009.

The remainder of the assessment submitted for Morrow County FY 2008 remains relatively unchanged and is included as follows.

AGING ISSUES: The aging population in Morrow County continues to be very proactive. Each of the three major communities (Heppner, Irrigon and Boardman) have active Senior Centers offering meals one time per week on different days with a bus offering transportation to the various facilities. This is especially important for those seniors who do not have transportation of their own, addressing nutritional as well as social needs. There is active participation of volunteers from the community and area churches at the mealsites on a rotational basis offering assistance in basic food preparation, serving and clean up. The Senior Centers offer frozen meals for home use to further support the nutritional needs of the seniors.

There is apartment style housing located above the senior meal site facility and also an assisted living facility in Heppner. The Health District offers

Home Health as well as Hospice services throughout the county. Pioneer Memorial Hospital is a 10 bed facility located in the southern part of the county in Heppner. The facility is especially important to the health of our residents as the next nearest facility is more than 50 miles away. Our senior population was greatly affected by the closing of a 30 bed skilled nursing facility here in Heppner, several years ago. However, the Health District has recently received funding for long term care projected to be available in the fall. The long term care will be housed within the Heppner hospital and there is already a waiting list for those in need. We offer information, resources and referral as available and applicable.

ALCOHOL & DRUG USE: There continues to be a severe Methamphetamine abuse problem in Morrow County. As mentioned before, Morrow and Umatilla County were awarded federal funds jointly and have formed the Blue Mountain Task Force Team. This drug use in and of itself has a tremendous impact on the families and communities within Morrow County. Our county Behavioral Health continues to offer Drug and Alcohol counseling on an individual as well as a group basis. However, one of the barriers to A & D services is resources for payment of services. This has made it very difficult, if not impossible for some clients to obtain services due to this barrier. There is also a significant alcohol problem here in our county. It seems to be socially acceptable as a means to celebrate with many adults condoning and at times even encouraging and contributing to the participation of minors. There is also a parallel acceptance of alcohol and tobacco (particularly chewing tobacco) use which reflects the “cowboy mentality” of this rugged rural county. Anecdotally, there also seems to be a strong link with substance abuse and domestic violence issues. There has long been a problem in Morrow County with domestic violence and also child abuse and neglect. We are currently ranked 26th for Child Abuse, in the County Rankings for the Child Well-Being index. There was a time in the not so distant past in which we had the highest percentage for child abuse and neglect in the state. Although we have shown improvement overall, this is clearly an ongoing struggle with many related factors.

BIRTH DEFECTS: The rate of birth defects for our county is relatively low although abuse of alcohol, tobacco and illicit drug use are all higher than each of the state rates. We also have a CaCoon program in place which offers home visiting and/or case management services with nursing professionals for children with special health needs from birth (or diagnosis) to 21

years of age. There are no prenatal care providers in the county although surprisingly, our low birthweight rate is very comparable with the state rate.

BIRTHS: The number of births for Morrow County in 2005 was 156. The only hospital located within the county does not offer delivery services. Usually deliveries take place in county, only if it is a planned home birth or an emergency delivery and in 2003, there were neither. The majority of Morrow County deliveries take place in Umatilla County. A limited number of residents travel to Washington State or to Wasco-Sherman County for delivery services. The low birthweight rate is very comparable with the state rate and our infant mortality remains relatively low.

CANCER MORBIDITY AND MORTALITY: Malignant Neoplasm is the leading causes of death in the county. Not surprisingly, malignant neoplasm also has the largest impact on years of potential life lost before age 65.

CHRONIC DISEASE: The chronic diseases which are the most statistically significant are cardiovascular disease, cancer and diabetes. We offer educational materials and handouts but do not have any type of formal education in place. Blood pressure checks are also offered free of charge.

COMMUNICABLE DISEASE: The number of communicable disease cases remain relatively low for our county although given our small population, even a variance of as little as one case can change the rate significantly. There is a fulltime CD nurse funded by the preparedness program which has been a huge asset to our county. Disease investigation and follow up is completed in a timely fashion. She works closely with the PCP's, area hospitals, HRSA, labs, Vector Control, Emergency Management and most recently the Extension Office, Fish and Wildlife and others as needed. Information related to health risks, trends or current outbreaks is dispersed as appropriate.

DEATHS AND CAUSES OF DEATH: The leading cause of death is malignant neoplasm followed closely by heart disease. It is also worth noting that the rate of tobacco linked deaths (40.7) is almost twice that of the state (22.5).

DENTAL: The availability of dental care is limited with one provider rotating services offered at each end of the county. Additionally the FQHC located on the north end of the county now offers a contracted service of a

mobile dental van providing emergency care on a limited basis. There is a huge need for these services among our adult population without adequate resources and among our large undocumented population. We provide education regarding prevention of baby bottle mouth decay. We also continue to give toothbrushes as a reward following immunization with education regarding oral health.

DIABETES: Diabetes remains a statistically significant chronic disease within the county. There are no specific services or educational opportunities targeted specifically to diabetes at this time. Public Health offers written materials including basic diet exchanges.

DOMESTIC VIOLENCE: Domestic violence continues to be a present problem here in our county as it is elsewhere. There are many factors which may contribute to the violence. Our income per capita is lower than the state (ranked 30th) and our unemployment rate is higher as well (at 24th). Additionally the presence of drug and alcohol abuse issues mentioned earlier is believed to be a significant factor. Domestic violence services are offered on a part time basis (one day per week), in Boardman by a bilingual bicultural support worker.

ELEVATED BLOOD LEVELS: Neither Public Health nor the PCP's within the county currently offer blood lead level screening.

EMERGENCY PREPAREDNESS: Public Health is actively involved in CSEPP activities, collaborating with and participating in their annual exercise. We continue to be in the process of procuring secure wireless access across a large portion of the county (geographically). We currently have memorandums of understanding in effect with Umatilla County. We currently have a wireless system in both of the Health offices as well as two mobile "suitcase" that all of our vehicles are equipped (with antennae) to utilize.

FOOD BORNE ILLNESS: Morrow County assumed responsibility of Environmental Health 01/01/06 under a sub-contract with Umatilla County Health Dept. We also remain peripherally involved in environmental issues and would anticipate active involvement in the event of a Food Borne illness and subsequent investigation.

IMMUNIZATIONS: Public Health is currently the only provider of immunizations within the county. We offer immunizations three days per week between the two offices. In our immunization plan last year we chose to target reducing missed opportunities in our efforts to improve our immunization rates overall. The percent of Hepatitis B dose #3 obtained by 24 months of age has risen from 79.6% (in FY 2004) to 93 % (in FY 2006). We also make frequent referrals to immunize through the home visiting program and other services we provide.

INCIDENCE OF FECAL ORAL TRANSMISSION OF DISEASE: In the past there have been incidences of recreational water exposure to rivers and streams, or within the farm environment. There is a natural increase in risk related to a rural, country environment and subsequent possible exposure.

INJURY MORBIDITY AND MORTALITY: The most recent data of 2003 reveals no successful suicides although there were two suicide attempts. There were a total of four deaths caused by unintentional injury in 2003 due to the following; 1- drowning, 2- MVA and 1- fall (unsure if any were alcohol related). A high priority is safety in the car with a strong emphasis on seat belt usage and carseat restraint systems for children. There are currently five Carseat Technicians within the health department. We offer infant/toddler carseats as well as booster seats in a variety of settings. Clients may access education, hands on instruction and/or appropriate seats at the clinic, through home visiting as a “one to one” and at community functions or health fairs. The seats are available at a greatly reduced price, or we do not charge at all if the client is unable to pay. We have been able to continue the provision of seats due to a generous grant received from ACTS Oregon a few years ago. We do so by requesting payment of \$20 (approx. half of the actual cost) with funds received used to purchase additional seats.

LIQUID AND SOLID WASTE ISSUES IN THE AREA: The Finley Buttes Land Fill has been located within the county for a number of years and has not been cause for concern. There is a potential problem associated with the presence of the Umatilla Army Depot chemical stockpile and storage as well as destruction (disposal) of the chemicals. Other issues are the location of Hanford, located to the north (across the Columbia River in Washington State) and also private sewer systems.

LOW BIRTH WEIGHT : In spite of our high risk OB population and the lack of prenatal care within the county, the low birthweight rate is very comparable with the state rate. (See related info in the Prenatal Section)

MENTAL HEALTH: Behavioral Health services are currently offered as a department administered by the county. However, the provision of services will be changing soon as the department has partitioned the County Court to be a private non-profit entity. The County Court granted the request and the department is currently in the process of restructuring with a planned start date of 07/01/07. It is anticipated that this will be a “seamless transition” with no perceivable changes in client services. One key focus for change was the ability of Mental Health to apply for additional funds or grants (in an effort to expand services) if the program is administered independent of the county.

PHYSICAL ACTIVITY, DIET AND OBESITY: These are all areas of concern for our county. Education and information are provided within many of the Public Health programs such as Family Planning and home visiting. These topics are also discussed and clients are counseled regarding their BMI with an emphasis on healthy activities, lifestyle and nutritional choices.

POPULATION: (Gender, Age, Race, Geography and Socio-economic status)

The certified population estimate for 2006 is 12,125. The county extends from the Columbia River on the north to the Blue Mountains on the south and consists of 2059 square miles. The elevation varies from 250 feet on the Columbia River to 6,000 feet in the Blue Mountains. There are five major communities; the cities of Boardman and Irrigon along the Columbia River on the north and Ione, Lexington and Heppner located further south. The two community centers are separated by approximately 40 miles of Navy Bombing Range and farm land. The socio-economic status varies from one end of the county to the other with a greater than the state average of residents below 100% of FPL. County wide, the number of students eligible for Free/Reduced lunches is >50%. The majority of our population is aged 0-18, with a rate of 20 (per 1,000) compared with the state rate of 12 (per 1000). The Hispanic population accounts for approximately 24% of the total population. However, the percent of Hispanic school students on the north end of the county is >50%. Other racial and/or ethnic minorities are present in very small numbers.

PREMATURE BIRTHS: Data was not located specific to our county for premature births. Data relating to Low Birth Weight was reviewed for a relative comparison of infants born prior to 37 weeks gestation. The county rate for all Low Birthweight infants is 59.1 (per 1,000) compared with the state rate of 61.4 (per 1,000).

PRENATAL CARE: There are no providers of prenatal care located within the county. This continues to be a concern as the Oregon benchmark reveals the County to be ranked at 35th in the state. The rate for inadequate Prenatal care (11.8), is more than twice that of the state (5.5). Public Health participates in the Oregon Mother's Care (OMC) program to expedite the process of applying for the OHP and an appointment is scheduled usually the same day, with the PCP in an effort to improve early access to prenatal care. A small amount of Maternal Child Health funding is utilized each year to pay a stipend for a limited number of clients that are ineligible for OHP supports. The Hermiston Community Health Clinic (located approx. 30 miles away in Hermiston) is the only current "provider" for prenatal care. Originally we had hoped that prenatal care could be accessed within the county through the FQHC. Although this was their goal, they were unable to entice a provider to come to the FQHC to provide the needed care to clients, and instead they have had to adopt a method similar to ours in which they refer prenatal care to another provider.

SAFE DRINKING WATER: The safety of drinking water is monitored through a State DHS facility located in Umatilla County (Pendleton). Issues, concerns or questions regarding the safety or monitoring of water systems are referred to this agency.

SAFETY NET MEDICAL SERVICES: Public Health was involved in a process to apply for Federal Funding to support an FQHC for the Boardman area (in the northern portion of the county) approximately two years ago. The request was successful and the Columbia River Community Health Services began operating in January of 2005. This spring, the FQHC was required to reapply for funding to continue as an FQHC. Morrow County Public Health provided a letter of support of the services they provide. As mentioned above, one of the primary goals was to provide prenatal care within the county but they have had to refer to a PCP located in Hermiston. The county Health District is also very supportive, offering services on a sliding scale fee and ensuring that no one is refused services for inability to pay. They also have facilities located on both ends of the county.

TEEN PREGNANCY: The 2003 benchmark data reveals an overall improvement in the percentage of teen pregnancies and we are currently ranked at 21. Historically, when reviewing data over a period of several years, the rate has remained relatively stable. Of the two abortions documented in the 2003 data, both were for women older than 20 yrs of age.

TOBACCO USE: Tobacco use during pregnancy (15.5) is identified as being higher than the state rate (12.0). The rate of tobacco linked deaths (40.7) is almost twice that of the state (22.5).

UNINTENDED PREGNANCY: There were two induced abortions for our county in the 2003 data (both were for women > 20 years of age). Although there is a significant number of pregnancies identified as unintended, anecdotal evidence often suggest that there were those clients who were later pleased at the prospect of parenting. This is not to say that these women would not have benefited from family planning had they accessed services before the pregnancy. We also offer emergency contraceptive services.

UNDERAGE DRINKING: This continues to be a very real and ever present concern in Morrow County. It is believed to have roots to our western/rural culture and “country living”. This is a difficult and complex problem in our communities with teen drinking having the covert support of many adults (at best promoting “responsible drinking” which does not address the legal issue), the perception that law enforcement does not always penalize in a fair manner throughout the county and within the cities (county deputies patrol both) and advertisements elsewhere that promote this activity. Although there have been alcohol related tragedies in various county communities, the perception of teens often prevail in the belief that “this won’t happen to them”. The county schools continue to discourage underage drinking, with a policy in place for abstaining from alcohol and other drugs if participating in sports and when attending school or school sponsored events. Morrow County School District also began piloting random drug testing in the Heppner High School, beginning this last fall (2005) as a requirement to participate in school athletics. The schools also recently brought in a presenter for a school assembly speaking to the risk of drinking and driving. They also brought a vehicle for display in which a young student from Oregon lost his life in a motor vehicle accident while driving under the influence.

Morrow County LPHA FY 09 Annual Plan

III. ACTION PLAN

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

A. Epidemiology and Control of Preventable Diseases and Disorders.

Morrow County Health Dept. (MCHD) meets this standard as outlined in the minimum standards for basic services as contained in statute (ORS 431.416). We currently have a half time CD Coordinator in addition to other CD nursing supports including mentoring and as a resource. Disease investigation and follow up continues to be completed in a timely fashion. We are planning to access the Web based investigation and follow up software program currently offered by Multnomah County. The LHD continues to work closely with the PCP's, area hospitals, HRSA, labs, vector control, emergency management, the extension office, Fish and Wildlife, and other agencies or individuals as appropriate. Information related to health risks, trends or current outbreaks is also relayed to others as needed or indicated.

B. Parent and Child Health Services, including Family Planning Clinics as described in ORS 435.205.

1. WIC:

N/A. WIC services for Morrow County are administered by another agency.

A MOA between Morrow County and WIC is currently being drafted by Umatilla Morrow HeadStart which we plan to have completed and in place within the next several weeks.

2. Immunizations:

The current Immunization plan for Morrow County has been reviewed with the most recent progress assessed in a separate report to be attached to the FY 09 Annual Plan.

New Immunization Plans (using the template provided) have been written for the upcoming year and will also be submitted as a separate attachment to the Annual Plan.

3. Family Planning:

MCHD meets this standard as outlined in the minimum standards for basic services as contained in statute (ORS 431.416). Currently family planning services are provided three days per week (two days in Boardman and one day in Heppner) for education, counseling and supplies. We also contract with a Nurse Practitioner to provide women's exams and STD checks two days per month (the majority of which are) in Boardman with the exception being two exam days per year in Heppner. The family planning program continues to be very successful with the continued steady addition of new clients. The Oregon Family Planning FY 07 Data Review reveals that 57% of the county's Women in Need (WIN) Population are served by Public Health. We also offer the Oregon Mother's Care (OMC) program to expedite the process of follow up after a positive pregnancy test; assisting the client in identifying and accessing resources to support and encourage access to early prenatal care.

Note: The Family Planning FY 09 Annual Plan was submitted 01/23/08.

We offer Maternity Case Management (MCM), Babies First, and CaCoon visits but these programs are limited by our number of staff. We are also the county provider through the Commission on Children and Families for the Healthy Start program which we have integrated with our other home visiting programs (MCM, Babies First and CaCoon programs). An RN provides the supervision of all of the home visiting programs and RN staff also provide screening, follow-up and referral as indicated.

4.MCH Programs:

A. Perinatal Health

The Perinatal Health goal is to increase access to early and adequate prenatal with the belief that this will positively impact our preterm Delivery and low birth weight rates.

Current Condition or Problem:

As noted previously, the lack of Prenatal Care availability in Morrow County is a huge barrier for residents in accessing care. According to the 2007 Oregon Progress Board Report, Morrow County is currently ranked 35th in the state for Prenatal Care. The Oregon Vital Statistics 2005 Annual Report reveals an Inadequate Prenatal Care rate for Morrow County of 13.6% which is significantly different than the state rate of 5.8%.

Goals:

The primary goal is to increase the number of women accessing early prenatal care and reducing the overall rate of those receiving inadequate care. As mentioned above, the hope is this would have a positive impact resulting in a decrease in preterm delivery and low birth weight.

Activities:

Morrow County Public Health continues to participate in the Oregon Mother's Care (OMC) program. The goal is to expedite the OHP application process so that women can then access early prenatal care more easily (without the barrier of additional financial burden). Often times the initial prenatal visit appointments is "scheduled" that same day. A small amount of Maternal Child Health funding is utilized each year to pay a stipend for a limited number of clients that are ineligible for OHP supports. There is a contract for Prenatal Care in place with Hermiston Community Health Clinic (located approx. 30 miles away) which is the only PCP facility willing to provide this service for our clients.

The FQHC located in Boardman has a similar program in place and MCHD has offered to enroll any Morrow County resident presenting to their clinic for care, meeting eligibility requirements.

Evaluation:

Use of funding appropriately in support of prenatal care as evidenced by documentation of those clients served and the submission of quarterly Revenue & Expenditure reports. In Addition, this will be evidenced by improved county statistics for access to early prenatal care and a decline in percentage of those women receiving inadequate care.

B. Infant and Child Health**Current Conditions or Problem:**

We continue to struggle with limited nursing time to devote to the various home visiting programs. There is a Maternal Child Health Supervisor that oversees all of the home visiting services including the Healthy Start program. In addition, there is one full time nurse that shares job duties with the clinic and home visiting. Although services provided continue to be limited, we have increased our offering and provision of Maternity Case Management. Other home visiting services include Babies First, CaCoon and Healthy Start with many of the same staff members providing care.

Goals:

To increase the number of total clients served through our home visiting services.

Activities:

Contact both WIC and our Prenatal (contracted) Care provider (HCHC) to discuss possible missed opportunities for referral of eligible clients to MCHD for enrollment into this program for prenatal care.

Evaluation:

Demonstrate an increase in the number of Prenatal, Postpartum and infant clients served through our home visiting programs.

C. Environmental Health.

MCHD meets this standard as outlined in the minimum standards for basic services as contained in statute (ORS 431.416). Environmental Health services are contracted to Umatilla County.

D. Health Statistics.

MCHD meets this standard as outlined in the minimum standards for basic services as contained in statute (ORS 431.416). NOTE: Vital Statistics are maintained in the County Clerks office.

E. Health Information and Referral Services.

MCHD meets this standard as outlined in the minimum standards for basic services as contained in statute (ORS 431.416). Health education and information is provided to clients as indicated with referral as appropriate.

F. Other Issues

No other substantial changes to report.

IV. Additional Requirements

The Morrow County LPHA is the County Judge and the Board of Commissioners of which he is a part. The Morrow County Court also oversees the local CCF as a department separate from the Public Health Department.

The Public Health Department and the LCCF work very closely together on a variety of issues including the completion of the most recent Comprehensive Plan January 2008.

See the attached Organizational Chart for additional information and clarification.

V. Unmet Needs

One of the largest gaps of Public Health services in Morrow County has already been addressed regarding the lack of Prenatal Care.

VI. Budget

Projected Revenue sheets to be submitted in July

Preliminary Approval per County of Public Health budget for FY 2009 (available upon request).

Contact Information for Morrow County budget information is as follows:

Morrow County Accountant
P.O. Box 867
Heppner, Or 97836

Phone (541) 676-5616

Morrow County LPHA FY 09 Annual Plan

VII. Minimum Standards

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

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

Organization

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

12. Yes No ___ All positions have written job descriptions, including minimum qualifications.
13. Yes No ___ Written performance evaluations are done annually.
14. Yes No ___ Evidence of staff development activities exists.
15. Yes No ___ Personnel records for all terminated employees are retained consistently with State Archives rules.
16. Yes No ___ Records include minimum information required by each program.
17. Yes No ___ A records manual of all forms used is reviewed annually.
18. Yes No ___ There is a written policy for maintaining confidentiality of all client records which includes guidelines for release of client information.
19. Yes No ___ Filing and retrieval of health records follow written procedures.
20. Yes No ___ Retention and destruction of records follow written procedures and are consistent with State Archives rules.
21. Yes No ___ Local health department telephone numbers and facilities' addresses are publicized.
22. Yes No ___ Health information and referral services are available during regular business hours.
23. Yes No ___ Written resource information about local health and human services is available, which includes eligibility, enrollment procedures, scope and hours of service. Information is updated as needed.

Please Note:

All Vital Statistics are maintained at the County Courthouse in the Clerk's office.

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.

Note: The Medical Examiner is “housed within” the County DA’s Office.

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

MCHD assumed responsibility for Environmental Health services 01/01/06 with a Sub-Contract for services in place with Umatilla County Health Department.

47. Yes No ___ Food service facilities are licensed and inspected as required by Chapter 333 Division 12. **EH Services per UCHD (as above).**
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.

Note: The Oregon DHS Has a Drinking Water Program office located in Umatilla County which address' drinking water issues for Morrow County.

51. Yes N/A No ___ Each drinking water system conducts water quality monitoring and maintains testing frequencies based on the size and classification of system. **State DHS (as above).**
52. Yes N/A No ___ Each drinking water system is monitored for compliance with applicable standards based on system size, type, and epidemiological risk. **State DHS (as above).**
53. Yes N/A No ___ Compliance assistance is provided to public water systems that violate requirements. **State DHS (as above).**
54. Yes N/A No ___ All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken. **State DHS (as above).**
55. Yes X No ___ A written plan exists for responding to emergencies involving public water systems. **Response to water emergencies is addressed within current emergency plans. Other services are per State DHS (as above).**
56. Yes N/A No ___ Information for developing a safe water supply is available to people using on-site individual wells and springs. **State DHS (as above).**
57. Yes N/A No ___ A program exists to monitor, issue permits, and inspect on-site sewage disposal systems. **Services per State DHS.**
58. Yes N/A No ___ Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12. **EH services are provided per Umatilla County.**
59. Yes N/A No ___ School and public facilities food service operations are inspected for health and safety risks. **EH services are provided per Umatilla County.**
60. Yes N/A No ___ Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12. **EH services are provided per Umatilla County.**
61. Yes N/A No ___ A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste. **Services are provided per State DHS.**

62. Yes N/A No ___ Indoor clean air complaints in licensed facilities are investigated. **Services are provided per Umatilla County and/or State DHS.**
63. Yes N/A No ___ Environmental contamination potentially impacting public health or the environment is investigated.
Services are provided per Umatilla County and/or State DHS.
64. Yes N/A No ___ The health and safety of the public is being protected through hazardous incidence investigation and response.
Services are provided per Umatilla County and/or State DHS.
65. Yes N/A 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.
Services are provided per Umatilla County and/or State DHS.
66. Yes N/A 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.
Services are provided per Umatilla County.

Health Education and Health Promotion

67. Yes X No ___ Culturally and linguistically appropriate health education components with appropriate materials and methods will be integrated within programs.
68. Yes X No ___ The health department provides and/or refers to community resources for health education/health promotion.
69. Yes X No ___ The health department provides leadership in developing community partnerships to provide health education and health promotion resources for the community.
70. Yes X No ___ Local health department supports healthy behaviors among employees.
71. Yes X No ___ Local health department supports continued education and training of staff to provide effective health education.
72. Yes X 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
Services are provided per Umatilla-Morrow HeadStart
 - b. Yes No ___ Family Planning
 - c. Yes No ___ Parent and Child Health
 - d. Yes No ___ Older Adult Health (**As appropriate**)
 - e. Yes No ___ Corrections Health (**There are no corrections facilities located within Morrow County**)
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.
This is accomplished through the provision of information and/or referral to the appropriate resource/s.

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.
Use of fluoride is promoted through education.
92. Yes No ___ Injury prevention services are provided within the community.

Primary Health Care

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

95. Yes No ___ The local health department advocates for individuals who are prevented from receiving timely and adequate primary health care.
96. Yes No ___ Primary health care services are provided directly or by referral.
97. Yes No ___ The local health department promotes primary health care that is culturally and linguistically appropriate for community members.
98. Yes No ___ The local health department advocates for data collection and analysis for development of population based prevention strategies.

Cultural Competency

99. Yes No ___ The local health department develops and maintains a current demographic and cultural profile of the community to identify needs and interventions.
100. Yes No ___ The local health department develops, implements and promotes a written plan that outlines clear goals, policies and operational plans for provision of culturally and linguistically appropriate services.
101. Yes No ___ The local health department assures that advisory groups reflect the population to be served.
102. Yes No ___ The local health department assures that program activities reflect operation plans for provision of culturally and linguistically appropriate services.

Health Department Personnel Qualifications

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

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

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

- 104. Yes ___ No The local health department Supervising Public Health Nurse meets minimum qualifications:**

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

AND

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

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

105. Yes N/A No ___ The local health department Environmental Health Supervisor meets minimum qualifications:

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

OR

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

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

106. Yes 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.

<u>Terry Tallman, County Judge</u>	<u>Morrow County</u>	<u>05/01/08</u>
Local Public Health Authority	County	Date

VI. Minimum Standards Response
Regarding The Health Department Personnel Qualifications
(Questions #103 and #104)

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

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

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

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

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

AND

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

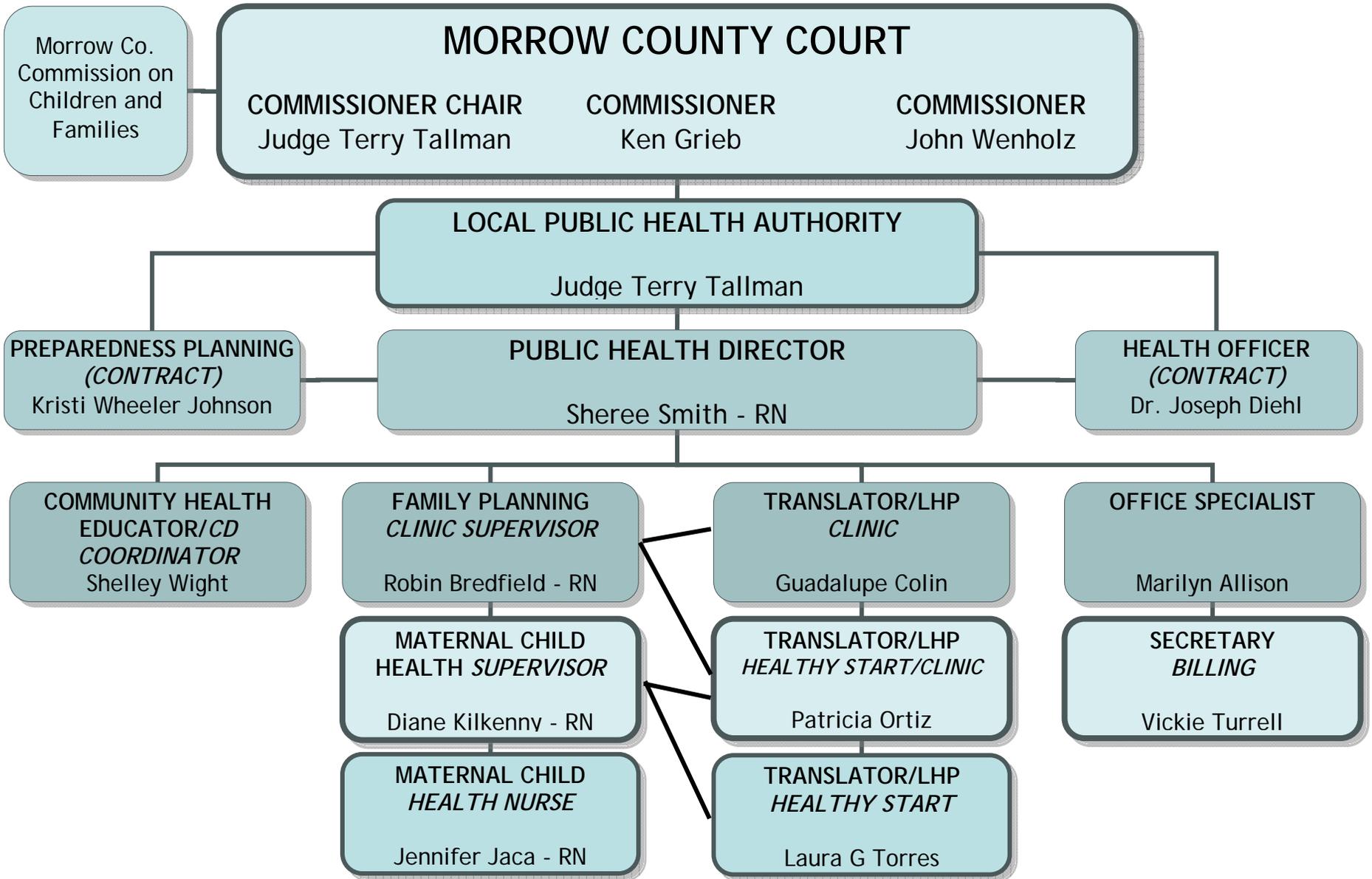
If the answer is “No”, submit an attachment that describes your plan to meet the minimum qualifications.

Both of the questions (#103 and #104) refer to the minimum standards for the Public Health Administrator and the Supervising Public Health Nurse positions as listed above. As discussed in previous Annual Plans, not all of these requirements have been met for these positions here in Morrow County.

We are a small rural county which employees three Community Health Nurses (CHN's) in addition to the Administrator/Supervising nurse position/s. Although the CHN's take on some of the supervisory duties of other LHD staff, the position of Administrator and Supervising Public Health Nurse are held by the same person.

The Public Health Administrator/Supervising Public Health Nurse graduated from a Diploma School of Nursing and has a current RN license. Prior to starting her career in Public Health she worked at Pioneer Memorial Hospital as a charge nurse for twelve years. She has many years of experience in Public Health having worked for this entity for the past 17 years and serving in her current position for the last six years.

She has explored some of the options available through a variety of educational institutions, to expand her educational background. No definitive plans have been made to pursue future institutional academics at this time.



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

FY'09

July 1, 2008 to June 30, 2009

Agency: Morrow County

Contact: Sheree Smith

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

Problem Statement	Objective(s)	Planned Activities	Evaluation
Changes in the FPEP program requiring documentation "proof" at the time of enrollment to attain eligible status has made it difficult for clients to comply. This additional fiscal burden may negatively impact the level of service we provide	1. Increase revenue by actively encouraging clients to make donations.	<ul style="list-style-type: none"> • Discuss donation policy; staff to encourage client to pay what they are able at the time of service • This policy is to be observed consistently with every client. 	<ul style="list-style-type: none"> • Quarterly and Fiscal Year End Revenue reports. • Staff Feedback
	2. Continue to provide a Super Bill to each client at each FP service.	<ul style="list-style-type: none"> • Provide a Super Bill at each visit so that client is aware of the value of the service received. 	<ul style="list-style-type: none"> • Staff Feedback
	3. Increase the number of eligible clients by encouraging clients to provide the necessary documentation.	<ul style="list-style-type: none"> • Provide a "reward" back to the client once all required information is provided. 	<ul style="list-style-type: none"> • Evaluate the number of rewards given. • Compare percentage of eligible clients before and quarterly, after the implementation of the policy.
Information inserts of BCM have limited information, and the information usually is not available in Spanish.	1. Increase client knowledge of their chosen BCM.	<ul style="list-style-type: none"> • Provide method specific Fact sheets available in English and Spanish to be given to each client at the time service. 	<ul style="list-style-type: none"> • Quarterly and Fiscal Year End Revenue reports. • Staff Feedback • Informal Client Feedback

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

Problem Statement	Objective(s)	Planned Activities	Evaluation
High “No Show” rate for scheduled Family Planning exam clinics resulting in scheduling gaps causing ineffective use of the contracted FNP.	1. Increase percentage of clients presenting for annual exam appointment as scheduled.	<ul style="list-style-type: none"> • Provide client with an appointment card. • Telephone reminder of appointment to client. • Stress importance of exam to client in order to continue with BCM of choice. • Maintain “waiting list” of clients to be called if an opening occurs. 	<ul style="list-style-type: none"> • Review and compare the no show rate at the exam clinics before implementation of the planned activities and quarterly throughout FY 2009.

Progress on Goals / Activities for FY 08
(Currently in Progress)

Goal / Objective	Progress on Activities
<p>#1 Changes in FPEP eligibility requirement resulting in fewer “eligible” clients causing decreased revenue.</p> <ul style="list-style-type: none"> • Obtain revenue through donations. • Provide Super Bill to increase the clients knowledge of the value of the service received. 	<p>There has been a very small amount of donation revenue received since the implementation of the donation policy (as identified in quarterly fiscal report). There has not been any client feedback obtained and there has been limited informal staff feedback. Donations have not been requested consistently nor have clients been consistently informed regarding the actual value of the service they were provided. This is one of the reasons that we chose to continue working on this problem in FY 09.</p>
<p>#2 Limited access to FP exams (no Clinics at the Heppner site).</p> <ul style="list-style-type: none"> • Increase access by providing FP exam clinics in Heppner. 	<p>FP exam clinics are offered quarterly in Heppner with first priority given to those with special needs or other barriers. By increasing the number of clinics offered it will enable clients to access services more quickly.</p>
<p>#2 Cont. (from above) Offer same day appointments at clinic sites in Heppner and Boardman.</p> <ul style="list-style-type: none"> • Implement same day appointment with “walk-ins” cont. in Heppner. 	<p>Same day appointments have been implemented in the Heppner clinic in addition to “walk-ins” as a way of assuring that the client will receive services that day. Clients returning for services are also encouraged to schedule their next appointment before leaving the clinic (i.e. returning for Lab results). Clients are also scheduled for their annual exams the same day that they first present for Family Planning services. Public Health pamphlets have been shared with community partners on a limited basis.</p>

Operational Definition of a Functional Local Health Department (LHD) Metrics LHD Capacity Assessment Tool

Directions:

- **Using the scale below, score each indicator based on the capacity within your LHD; including both capacity provided by your HD staff and through contracts that you have with outside entities.**

- **In the comment section, following each focus area indicators, please identify any outside entities (non-contract) at the local, regional or state level that provide capacity to fulfill the indicators in that section.**

- **The items in the shaded boxes to the right of the scoring column are supplemental information (Illustrative Evidence) to help clarify the focus areas being evaluated.**

Score	Description
0	No capacity
1	Minimal capacity (< 25%)
2	Moderate capacity (25% - 50%)
3	Significant capacity (51% - 75%)
4	Optimal (76%-100%)

County **Morrow** Date **03/27/08**

Name of person completing survey **Sheree Smith**

ESSENTIAL SERVICE I: Monitor health status and understand health issues facing the community

STANDARD I-A Obtain and maintain data that provide information on the community’s health (e.g., provider immunization rates; hospital discharge data; environmental health hazard, risk, and exposure data; community-specific data; number of uninsured; and indicators of health disparities such as high levels of poverty, lack of affordable housing, limited or no access to transportation, etc.).

FOCUS: DATA COLLECTION, PROCESSING and MAINTENANCE

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD staff has expertise and training to collect, manage, integrate and display health-related data	<u>2</u>	<ul style="list-style-type: none"> ▪ A data set from a major data system ▪ Written documentation of process to contribute/maintain to register ▪ Report that demonstrates health assessment data being collected; or minutes or presentation to a meeting in which a profile of community health status is presented ▪ Listing of key staff names and degrees; conduct assessment of training and provide assessment results; ▪ Written description of current computer equipment and technology including brand, model, year
2. LHD uses appropriate equipment and technology	<u>3</u>	
3. LHD maintains and uses an information system(s) (e.g. email, shared electronic database files, intranet)	<u>3</u>	
4. LHD demonstrates an electronic linkage with local and statewide databases	<u>4</u>	
5. An electronic disease reporting system exists between the LHD and health care providers	<u>3</u>	
6. LHD has a process and protocols in place to maintain a comprehensive collection, review, and analysis of data from a variety of reliable sources	<u>1</u>	
7. LHD collects and reviews primary data (e.g. community surveys; disease reporting) and secondary data (state health department data; census data; hospital discharge data) from a variety of reliable sources	<u>1</u>	
8. LHD contributes to and/or maintains a registry (e.g. log of all known events of certain type in the community--immunization; violence; communicable disease)	<u>2</u>	

Comments regarding non-contract entities providing services for this focus area:

STANDARD I-B. Develop relationships with local providers and others in the community who have information on reportable diseases and other conditions of public health interest and facilitate information exchange.

FOCUS: DISEASE REPORTING RELATIONSHIPS; MAKE DATA AND INFORMATION FLOW ROUTINE

Operational Definition Indicators	Score	Illustrative Evidence
2. LHD maintains a user-friendly (preferably electronic) system for reporting of data	<u>3</u>	<ul style="list-style-type: none"> ▪ List of providers and log of reports made ▪ Feedback provided on data reports ▪ Written summary that details on percentage of reports that are from providers ▪ Presentations, evidence of meetings held or conference organized (e.g. agenda), or educational materials distributed to promote provider relationships and reporting
3. LHD maintains a written and electronic list of health care providers and public health partners who may be disease-reporters	<u>3</u>	
4. A written policy/procedure exists that describes the method to assure that LHD staff can be contacted at all times	<u>4</u>	
5. Providers are educated and trained on collecting and reporting data to the LHD	<u>3</u>	
6. LHD uses a quality improvement process between LHD and providers to make it easy for providers to report	<u>2</u>	
7. Health care providers and other public health partners receive reports and feedback on disease trends and clusters	<u>2</u>	

Comments regarding non-contract entities providing services for this focus area.

STANDARD I-C. Conduct or contribute expertise to periodic community health assessments.

FOCUS: CONDUCT OR CONTRIBUTE EXPERTISE TO PERIODIC COMMUNITY HEALTH ASSESSMENTS

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD staff have the appropriate knowledge of standards and processes for conducting community health assessments	<u>1</u>	<ul style="list-style-type: none"> ▪ A Community Health Plan (CHP) with community health assessment

2. LHD staff are trained in the application of assessment methods	<u>1</u>
3. LHD staff can organize and manage an assessment process	<u>1</u>
4. A structured process for conducting the community health assessment is reviewed and adopted (i.e. APEX/PH, MAPP, etc.)	<u>1</u>
5. LHD organizes community health data (e.g. mortality, disease prevalence, risk factors, and other data) for assessment purposes	<u>1</u>
6. Broad participation of community stakeholders in the assessment process is secured.	<u>1</u>
7. A community health assessment process is conducted every five years	<u>1</u>

- Summary of community health assessment findings
- Community health assessment update

Comments regarding non-contract entities providing services for this focus area:

STANDARD I-D. Integrate data with health assessment and data collection efforts conducted by others in the public health system.

FOCUS: INTEGRATING DATA/DATA SHARING WITH COMMUNITY PARTNERS

Operational Definition Indicators	Score	Illustrative Evidence
1. A written protocol to integrate data exists	<u>1</u>	<ul style="list-style-type: none"> ▪ LHD or other agency report indicating diverse participation in assessment process ▪ Minutes demonstrating convening diverse groups in health assessment process ▪ Written documentation of membership in other groups that are conducting health assessment or data collection efforts ▪ Meeting minutes showing health data and community health assessments are shared ▪ Written protocol or description of the process used to share data
2. LHD develops and maintains relationships with community and public health system partners	<u>3</u>	
3. Assessment processes by community agencies include the LHD and community partners as participants	<u>2</u>	
4. LHD uses an electronic system to integrate assessment data from a variety of sources (e.g. database software)	<u>1</u>	

- Evidence that health assessment and data are available for public use (e.g. website, reports on how data is shared)

▪ **Comments regarding non-contract entities providing services for this focus area above.**

-
- **STANDARD I-E** Analyze data to identify trends, health problems, environmental health hazards, and social and economic conditions that adversely affect the public’s health.

▪ **FOCUS: DATA ANALYSIS**

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has a process in place to analyze and identify patterns in data	<u>1</u>	<ul style="list-style-type: none"> ▪ Evidence of an internal process reflecting data analysis (e.g., policies and procedures, meeting minutes, agency management team minutes, etc.) ▪ Documentation of having reported analysis findings to state (e.g., emails/logs of phone calls, analysis of local infectious disease data) ▪ Report and/or a presentation that demonstrates a comprehensive understanding of the health status and health problems most meaningful for the community in logical data groups ▪ Other documentation such as asset map of the community, Community Health Profile, GIS map detailing trends, health problems etc
2. LHD staff are competent in methods of data analysis and interpretation	<u>1</u>	
3. LHD draws inferences from data to identify trends over time, health problems, environmental, health hazards, and social and economic conditions that adversely affect the public’s health	<u>1</u>	
4. LHD graphs health data to indicate whether the problems identified by the community health assessment are improving or worsening	<u>1</u>	
5. LHD compares local data to other jurisdictions and/or the state or nation	<u>1</u>	
6. LHD conducts a small area analysis using GIS	<u>1</u>	
7. LHD conducts gap analysis of the needs of populations who may encounter barriers to services	<u>1</u>	
8. LHD makes data analysis usable to others	<u>1</u>	

Comments regarding non-contract entities providing services for this focus area above.

ESSENTIAL SERVICE II: Protect people from health problems and health hazards.

STANDARD II-A. Investigate health problems and environmental health hazards

FOCUS: ROUTINE OUTBREAK INVESTIGATIONS

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD expertise to carry out an investigation can be demonstrated	<u>3</u>	<ul style="list-style-type: none"> ▪ Report showing review process of health problems and environmental health hazards ▪ Electronic database is used with standardized case investigation protocols ▪ Information on leading industry in the community and any associated risks ▪ Information on local employment and related occupational risks ▪ Evidence of an appropriately conducted, documented and reported outbreak investigation (if applicable)
2. LHD uses a surveillance system to trigger investigations	<u>1</u>	
3. LHD has written protocols to document the investigation process, including identifying information about the disease, case investigation steps, reporting requirements, contact and clinical management, use of emergency biologics, and the process for exercising legal authority for disease control	<u>3</u>	
4. Data on health problems and environmental hazards are collected at regular intervals	<u>1</u>	
5. Data collected on health problems in the community are analyzed for trends and clusters	<u>1</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD II-B. Prevent, minimize, and contain adverse health events and conditions resulting from communicable diseases; food, water, and vector-borne outbreaks; chronic diseases; environmental hazards; injuries; and health disparities.

FOCUS: MITIGATION OF HEALTH PROBLEMS AND ADVERSE HEALTH EVENTS

Operational Definition Indicators	Score	Illustrative Evidence
1. HLD staff are trained to mitigate adverse health events	<u>3</u>	

2. LHD has protocols for minimizing and containing adverse health events	<u>3</u>	<ul style="list-style-type: none"> ▪ Copy of an electronic disease reporting template ▪ Quarterly self-assessment of investigation and reporting process ▪ Policies, procedures, or a detailed flow chart that describes the roles and responsibilities for local response. ▪ LHD internal log of disease reports not otherwise reported in an electronic form (e.g. well water, lead) with disposition of LHD activities to mitigate problem ▪ Demonstrate use of prevalence of conditions to target interventions, personal and community health interventions to mitigate chronic disease and injuries ▪ Evidence of public health response such as information releases on disease prevention and control
3. The appropriate number and type of staff (i.e. epidemiological capacity, clinical capacity) are available at the LHD or can be accessed to carry out protocols effectively	<u>2</u>	
4. LHD informs and educates the about adverse health events, including information such as the nature of the situation, how to respond, and where to find resources	<u>3</u>	
5. LHD implements the established epidemiological protocol for mitigation, including disease-specific procedures for mitigating an outbreak, such as providing prophylaxis, and conducting follow-up documentation and reporting	<u>3</u>	
6. LHD conducts routine programs to protect the public from vaccine preventable conditions, such as pneumonia and influenza	<u>3</u>	

Comments regarding non-contract entities providing services for this focus area above:

STANDARD II-C. Coordinate with other governmental agencies that investigate and respond to health problems, health disparities, or environmental health hazards.

FOCUS: FOCUS: WORKING WITH OTHER GOVERNMENTAL AGENCIES ON ROUTINE INVESTIGATION AND RESPONSE

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has protocols with other governmental agencies for mutual assistance in responding to specific health problems or hazards	<u>2</u>	<ul style="list-style-type: none"> ▪ List of governmental agencies that investigate and response to health problems and evidence of coordination, including meeting notes, agendas, logs of phone calls etc. ▪ Copies of memorandums of understandings
2. LHD establishes a planning committee with diverse partners	<u>2</u>	

		<ul style="list-style-type: none"> with other governmental agencies ▪ Written protocols/policy detailing the process for investigating/responding to health problems
3. LHD identifies partners in advance and protocols are developed to engage partners during an event	<u>3</u>	
4. LHD routinely communicates with other governmental agencies on health problems in the community	<u>3</u>	
LHD coordinates action with other governmental agencies		

Comments regarding non-contract entities providing services for this focus area above:

STANDARD II- D. Lead public health emergency planning, exercises, and response activities in the community in accordance with the National Incident Management System, and coordinate with other local, state and federal agencies.

FOCUS: TAKE LEAD IN EMERGENCIES THAT ARE PUBLIC HEALTH IN NATURE

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD staff demonstrate competency in preparing for and responding to public health emergencies	<u>3</u>	<ul style="list-style-type: none"> ▪ Local preparedness quarterly reports detailing preparedness activities and coordination with government agencies ▪ Copy of LHD response plan ▪ Evidence of LHD preparedness meetings with other government agencies including planning meetings minutes, calendar of meetings, email exchanges, logs of phone calls etc. ▪ Evidence of real event or exercise that evaluates policies, including meeting minutes from debriefing or After-Action Report ▪ Evidence of use of Project Public Health Ready Criteria
2. There is a protocol in place to engage volunteers during an event	<u>2</u>	
3. Emergencies that trigger use of the response plan are defined	<u>3</u>	
4. LHD develops a plan with emergency response partners that outlines responsibilities, communication networks, and evacuation procedures	<u>2</u>	
5. LHD leads the annual testing of its emergency response plan, through the use of drills and exercises.	<u>2</u>	
6. LHD leads in an annual revision of its emergency response plan	<u>2</u>	
7. LHD identifies volunteers and trains them	<u>1</u>	
8. LHD coordinates public health response capacity with local, state and federal agencies	<u>3</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD II-E. Fully participate in planning, exercises, and response activities for other emergencies in the community that have public health implications, within the context of state and regional plans and in a manner consistent with the community’s best public health interest.

FOCUS: PARTICIPATE WHEN OTHER AGENCIES ARE IN THE LEAD

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD is competent in emergency preparedness for public health and other types of emergencies that may have public health implications	<u>3</u>	<ul style="list-style-type: none"> ▪ Evidence of LHD participation in partner planning for emergencies including planning meetings minutes, calendar of meetings, email exchanges, logs of phone calls etc. ▪ Invitation to participate in partner exercises or evidence of participation in emergency response when LHD was not in the lead (e.g. press release, newspaper story) ▪ Evidence of real event or exercise that evaluates policies, including meeting minutes from debriefing or After-Action Report ▪ Evidence of use of Project Public Health Ready Criteria
2. LHD staff attends preparedness planning meetings and exercises sponsored by other organizations (e.g. regional exercises, state planning groups, local emergency management drills, etc.)	<u>4</u>	
3. LHD participates in local, regional and state all-hazards response planning	<u>3</u>	

Comments regarding non-contract entities providing services for this focus area above:

STANDARD II- F. Maintain access to laboratory and biostatistical expertise and capacity to help monitor community health status and diagnose and investigate public health problems and hazards.

FOCUS: ACCESS TO LAB AND BIOSTATS RESOURCES		
Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has current written protocols and/or guidelines for handling clinical and environmental laboratory samples based on standards	<u>3</u>	<ul style="list-style-type: none"> ▪ Quarterly reports/assessments indicating that staffing requirements are met ▪ Written protocols/procedures for access to state lab services ▪ Records, indicating appropriate requests for and response of monitoring, diagnosing and investigating health problems and hazards ▪ List of individuals fulfilling this capacity, job description for personnel (if applicable) or copy of consulting/contracting (if applicable)
2. LHD maintains a call-up protocol of epidemiological resources	<u>3</u>	
3. LHD maintains epidemiological and statistical expertise, including access to and consultations with appropriately trained epidemiologists	<u>3</u>	
4. LHD has a written procedures for surge capacity, with descriptions of how expanded lab capacity is made readily available when needed for outbreak response	<u>2</u>	
5. There is a current list of local and regional laboratories having the capacity to analyze specimens	<u>2</u>	
6. LHD assesses the availability of epidemiological expertise on a regular basis	<u>2</u>	
7. LHD implements a state-wide laboratory protocol for reporting, collecting, handling and transporting laboratory specimens	<u>3</u>	
8. LHD assesses the availability of laboratory expertise on a regular basis	<u>1</u>	
9. LHD uses epidemiologic, biostatistical and laboratory expertise when needed	<u>3</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD II- G. Maintain policies and technology required for urgent communications and electronic data exchange.

FOCUS: CAPACITY FOR EMERGENCY COMMUNICATIONS AND DATA EXCHANGE

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD maintains appropriate technology for 24/7 communications	<u>4</u>	<ul style="list-style-type: none"> ▪ Preparedness quarterly reports with checklist on emergency communication capacity ▪ Sample of written policy describing data exchange/urgent communications, including protocol of 24/7 communications policies ▪ Evidence of real event or exercise that evaluates policies, including meeting minutes from debriefing or After-Action Report
2. LHD maintains appropriate technology for electronic data exchange	<u>4</u>	
3. LHD updates protocols and contact information at least annually and makes readily available to staff.	<u>3</u>	
4. LHD uses multiple methods for dissemination of public health messages	<u>3</u>	
5. LHD tests its emergency data exchange capabilities annually	<u>3</u>	
6. Meeting minutes from debriefing or After-Action Report	<u>3</u>	

Comments regarding non-contract entities providing services for this focus area above.

ESSENTIAL SERVICE III: Give people information they need to make healthy choices.

STANDARD III a. Develop relationships with media to convey information of public health significance, correct misinformation about public health issues, and serve as an essential resource.

FOCUS: DEVELOP AND IMPLEMENT MEDIA STRATEGIES

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD develops and maintains a database of media partners and outlets available	<u>2</u>	<ul style="list-style-type: none"> ▪ List of current media contact ▪ Notes from meetings with media representatives on current and emerging public health issues ▪ Log of calls from media about public health events or stories ▪ Logs of calls to media about public health
2. LHD maintains a written protocol for communicating with the media	<u>2</u>	
3. LHD builds staff competency in working with the media	<u>1</u>	
4. LHD conducts an environmental scan and assessment of media outlets	<u>0</u>	

5. LHD develops a media strategy that includes formal (press releases) and informal opportunities for communicating with the media and responding to media requests	<u>3</u>	<ul style="list-style-type: none"> ▪ event or story ▪ Health reports disseminated to media ▪ LHD press releases and associated media news stories ▪ Written media strategy
6. LHD communicates routinely with media to raise awareness of public health and public health issues in the community	<u>1</u>	
7. LHD communicates with media on emerging events and situations to inform the public	<u>2</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD III-B. Exchange information and data with individuals, community groups, other agencies, and the general public about physical, behavioral, environmental, social, economic, and other issues affecting the public’s health.

FOCUS: GENERAL DATA AND INFORMATION EXCHANGE ON ISSUES AFFECTING POPULATION HEALTH

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD establishes a network to share data with stakeholders	<u>1</u>	<ul style="list-style-type: none"> ▪ Notes from meetings with community stakeholders (e.g. open forums, topical health issue meetings, such as infectious disease, preparedness MCH, etc.) demonstrating communication and exchange with key community partners (e.g. evidence that LHD staff presentation of report) ▪ Report identifying organizational roles and responsibilities for service delivery (e.g., preparedness roles) ▪ Health reports disseminated by LHD ▪ Topical communication (e.g. in blast faxes, health alerts, etc.) ▪ LHD newsletters ▪ LHD web site with tracking capabilities
2. LHD continuously develops current information on health issues that affect the community	<u>1</u>	
3. LHD has protocols and/or strategies in place to communicate health information periodically	<u>2</u>	
4. LHD has a written protocol in place to respond to specific information requests	<u>1</u>	
5. LHD uses its stakeholder network to gather information and to provide data and information on community health issues	<u>1</u>	
6. LHD uses principles of social marketing to understand the information needs of specific populations	<u>1</u>	
7. LHD informs the public about how to obtain health data and information from the department	<u>1</u>	

8. LHD responds to data requests in a timely manner	<u>2</u>	<ul style="list-style-type: none"> ▪ Protocols for communication with target audiences (i.e. individuals, community groups, other agencies, and the general public)
---	----------	---

Comments regarding non-contract entities providing services for this focus area above.

STANDARD III -C. Provide targeted, culturally appropriate information to help individuals understand what decisions they can make to be healthy.

FOCUS: PROVIDE HEALTH INFORMATION TO INDIVIDUALS FOR BEHAVIOR CHANGE

Operational Definition Indicators	Score	Illustrative Evidence
1. Accurate and current information is available in formats that are culturally appropriate, linguistically relevant and accessible to target and special populations	<u>3</u>	<ul style="list-style-type: none"> ▪ Publications of health information in different languages represented in the community including brochures, hand-outs etc. ▪ Evidence of cultural competency training provided for LHD staff and contractors, including copy of training, schedule of training, agenda, attendance, or evaluation ▪ LHD annual report demonstrating how services are targeted to at risk populations ▪ Evidence of use of local media for health messages including press release, health story ▪ Log tracking health education meeting attendance for reach into target populations ▪ Protocols for testing health messages with target audiences ▪ Surveys conducted to evaluate whether target audience understood health messages ▪ Tracking system for program participants by race, ethnicity, gender, sexual orientation
2. LHD staff demonstrates capacity to develop materials and conduct education campaigns designed to improve health behaviors	<u>3</u>	
3. LHD uses the community health assessment to develop health education information	<u>1</u>	
4. LHD assesses the target population for how they accept information	<u>1</u>	
5. LHD provides health education services in the language used by, and within the cultural context of, the target population	<u>3</u>	
6. Members of the target population participate in the development and distribution of health education materials	<u>2</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD III-D. Provide health promotion programs to address identified health problems.

FOCUS: HEALTH PROMOTION PROGRAMS FOR BEHAVIOR AND ENVIRONMENTAL/COMMUNITY CHANGE

Operational Definition Indicators	Score	<p style="text-align: center;">Illustrative Evidence</p> <ul style="list-style-type: none"> ▪ Report/justification that details how health promotion programs are linked to community health assessment and health improvement plan ▪ Health promotion program reports ▪ Inventory all health promotion programs, including free-standing programs and programs that are embedded in other programs ▪ Written procedures describe the systematic approach to health promotion information, including the development, distribution, evaluation, and revision process ▪ Records indicating training and/or materials for health promotion have been provided to community organizations. ▪ Program evaluation summaries, progress reports, or summaries of analysis demonstrate that key measure data are used as part of the process to improve the programs or to revise health promotion curricula ▪ Log or summary of technical assistance efforts ▪ Document the source of proven intervention strategies
1. LHD has an overall strategy/plan for its delivery of population-based health promotion and disease prevention programs (e.g. which programs are developed, how they are implemented, and when they are evaluated)	<u>2</u>	
2. LHD staff has health promotion knowledge and skills (e.g. social marketing)	<u>2</u>	
3. LHD staff are available to offer technical assistance to the community in development of health promotion programming	<u>2</u>	
4. LHD involves a variety of disciplines in the design and implementation of health promotion programs (e.g. Educators, Faith Institutions, Nursing, Environmental, Community-development for the built environment)	<u>1</u>	
5. LHD identifies populations at risk as potential target populations for health promotion programming	<u>1</u>	
6. LHD assesses the target population for how they accept information	<u>1</u>	
7. LHD demonstrates that program designs use proven intervention strategies	<u>0</u>	
8. LHD implements the appropriate program for identified target populations	<u>2</u>	
9. LHD evaluates health promotion efforts every two years, the results of which are used to improve programs.	<u>1</u>	
10. LHD develops and revises performance measures, goals and objectives for annual program planning based on information obtained through evaluation of health promotion activities.	<u>2</u>	
11. LHD provides technical assistance to communities and		

community agencies on health promotion activities 2

Comments regarding non-contract entities providing services for this focus area above.

ESSEMTIAL SERVICE IV: Engage the community to identify and solve health problems.

STANDARD IV-A. Engage the local public health system in an ongoing, strategic, community-driven, comprehensive planning process to identify, prioritize, and solve public health problems; establish public health goals; and evaluate success in meeting the goals.

FOCUS: COMMUNITY PLANNING PROCESS ENGAGING SYSTEMS PARTNERS

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has a community health planning structure in place	<u>2</u>	<ul style="list-style-type: none"> ▪ Community health needs assessment and community health plan ▪ Meeting minutes, membership lists, and attendance frequency for coalitions focused on public health topics (e.g. pandemic flu, cardiovascular disease prevention, etc.) ▪ Written description of the planning process and effort to engage the community and system partners ▪ A community health plan with at least one measurable outcome objective covering a 5-year time frame related to each priority health need and at least one measurable impact objective related to each outcome objective. ▪ Local performance assessment using NPHPS
2. LHD has the capacity to manage the planning process (e.g., trained staff, organized unit, assigned responsibilities)	<u>2</u>	
1. LHD recruits a broad range of community partners, stakeholders and constituents to participate in the community planning process	<u>2</u>	
2. LHD reviews and adopts a structured process for conducting community health planning (i.e. APEX/PH, MAPP, etc.)	<u>1</u>	
3. The planning team uses the community health assessment to inform the selection of priorities	<u>1</u>	
4. Community assets are identified	<u>1</u>	
5. Gaps are identified through analysis of the results with periodic surveys and other assessment information	<u>1</u>	
6. Community satisfaction is assessed and gaps are identified.	<u>1</u>	
7. Partnership effectiveness in improving community health	<u>1</u>	

is assessed	
8. Partnership effectiveness in improving community health is assessed	<u>0</u> Duplicate?
9. The performance of the public health system is assessed (in relationship to targets)	<u>1</u>
10. Goals and objectives are established in the plan	<u>2</u>
11. Plan identifies emerging issues which may require investigation	<u>1</u>
12. Strategies and best practices are selected to increase potential for success	<u>1</u>
13. Information about public health needs and priorities is disseminated to elected officials	<u>2</u>

Comments regarding non-contract entities providing services for this focus area above.

STANDARD IV-B. Promote the community’s understanding of, and advocacy for, policies and activities that will improve the public’s health

FOCUS: RAISE AWARENESS AND GAIN GENERAL PUBLIC SUPPORT FOR THE PLAN AND A DEEPER UNDERSTANDING OF PUBLIC HEALTH ISSUES

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has current information on health issues that affect the community readily accessible	<u>3</u>	<ul style="list-style-type: none"> ▪ Needs assessment and community health plan ▪ Presentations at public meetings, meeting agendas, or meeting notes ▪ Press release, newspaper clippings about community health priorities and public health ▪ Evidence of plan distribution including LHD website, newsletter, or distribution list
1. LHD conducts a community education and marketing process to increase the awareness of the community health improvement plan and its recommendations	<u>1</u>	
2. LHD uses a variety of methods (e.g. media, website) to disseminate the plan to the community	<u>1</u>	
3. LHD leads a process to assess and analyze effectiveness of public policy and community environment to improve health and shares the results publicly	<u>0</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD IV-C. Support, implement, and evaluate strategies that address public health goals in partnership with public and private organizations.

FOCUS: SUPPORT PARTNERS TO IMPLEMENT ACTION

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD staff are familiar with program planning methods	<u>2</u>	<ul style="list-style-type: none"> ▪ Grant proposals to fund community priorities developed/supported by LHD and other community agencies ▪ Letters of support for grant proposals ▪ Topic oriented coalitions: Lists of members, meeting frequency, meeting notes, etc. ▪ Media reports of partnerships/coalition implementation activities ▪ Linkage agreements among strategic partners
1. LHD staff is identified to establish and maintain partnerships and perform collective work	<u>2</u>	
1. LHD identifies community organizations that contribute to the Essential Public Health Services/program implementation	<u>2</u>	
2. System partner organizations’ work plans, action plans and program plans to address public health goals	<u>1</u>	
3. A policy agenda is developed	<u>0</u>	
4. System partner organizations align their program activities and/or organization plans with community objectives	<u>1</u>	
5. Resources are marshaled (e.g., human and financial) to conduct program activities	<u>1</u>	
6. Implementation progress is systematically monitored	<u>0</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD IV-D. Develop partnerships to generate interest in and support for improved community health status, including new and emerging public health issues.

FOCUS: DEVELOP PARTNERSHIPS TO SUPPORT PUBLIC HEALTH

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD maintains a directory of community organizations and systems partners	<u>2</u>	<ul style="list-style-type: none"> ▪ Community assessment and plan, including a description of the community participation process, a list of community groups involved in the process and method the community group uses to establish priorities ▪ Document direct and in-kind contributions from community agencies to support planned public health efforts ▪ Letters of support for grant proposals ▪ Lists of members of topic-oriented coalitions ▪ Linkage agreements among strategic partners ▪ Annual report listing external relationships maintained by the LHD ▪ Document use of best practices in evaluating partnerships
2. LHD marshals the resources needed to maintain partnerships (e.g. personnel, funding, policy changes, system change)	<u>2</u>	
3. LHD encourages constituent participation in community health activities	<u>3</u>	
4. LHD forms alliances or coalitions around specific public health policy issues	<u>1</u>	
5. LHD recruits individuals and organizations to play leadership roles on public health issues	<u>1</u>	
6. LHD participates in coalitions led by other community partners	<u>3</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD IV- E. Inform the community, governing bodies, and elected officials about governmental public health services that are being provided, improvements being made in those services, and priority health issues not yet being adequately addressed.

FOCUS: REPORTING PROGRESS, ADVOCATING FOR RESOURCES TO IMPLEMENT PRIORITIES

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD monitors its progress in implementing public health services and interventions	<u>2</u>	<ul style="list-style-type: none"> ▪ Dissemination list for community assessment and community health plan ▪ Newspaper articles, progress reports, website
2. LHD maintains a good working relationship with governing/legislative bodies	<u>3</u>	

3. LHD maintains capacity to interact with the legislative process	<u>2</u>	<p>postings, LHD annual reports etc.</p> <ul style="list-style-type: none"> ▪ Minutes of meetings at city councils, county boards sharing information about services provided ▪ Testimony and/or letters to elected officials about needed policy changes ▪ Summary of LHD evaluation of progress in achieving performance goals, including how budget was altered and needed change
4. LHD analyzes information to compare to performance to plan targets or benchmarks	<u>1</u>	
5. LHD generates and disseminates performance reports on public health services	<u>1</u>	
6. LHD provides testimony and information to governing body on public health policy	<u>2</u>	
7. LHD submits a budget justification that reflects program priorities and community needs	<u>3</u>	
8. LHD engages in public health policy development, identifying, prioritizing and monitoring public health policy issues	<u>2</u>	

Comments regarding non-contract entities providing services for this focus area above.

ESSENTIAL SERVICE V: Develop public health policies and plans

STANDARD V-A. Serve as a primary resource to governing bodies and policymakers to establish and maintain public health policies, practices, and capacity based on current science and best practices.

FOCUS: PRIMARY SCIENTIFIC RESOURCE FOR POLICY CHANGE IN PUBLIC HEALTH

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD staff are up to date with current public health topics	<u>3</u>	<ul style="list-style-type: none"> ▪ Letter to state from Board of Health confirming adoption of the community health plan ▪ Board of Health meeting minutes on presentation and discussion of community health assessment and plan ▪ A representative sample of Board of Health, City Council and/or County Board meeting minutes indicating discussion of public health policy issues ▪ Reports on LHD activities, press releases, annual reports, indicating major health
2. LHD staff are knowledgeable about the legislative process	<u>1</u>	
3. LHD maintains a written protocol for working with the legislative process	<u>0</u>	
4. LHD maintains formal and informal relationships with legislative and governing body(s)	<u>1</u>	
5. LHD maintains a database of legislative and governing bodies	<u>0</u>	
6. LHD has a tracking system in place to monitor public	<u>1</u>	

health issues under discussion by governing and legislative bodies		<p>policy, practice and capacity issues</p> <ul style="list-style-type: none"> ▪ Evidence/logs of calls from elected officials, and other government officials ▪ LHD staff serving on legislative or topical ad
7. LHD communicates routinely with legislative and governing bodies to raise awareness of current public health issues and emerging issues affecting the community	<u>1</u>	
8. LHD provides expertise to legislative and governing body(s) in setting public health priorities and planning public health programs	<u>1</u>	
9. LHD staff attends appropriate legislative events	<u>2</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD V-B. Advocate for policies that lessen health disparities and improve physical, behavioral, environmental, social, and economic conditions in the community that affect the public’s health.

FOCUS: POLICY ADVOCACY FOR HEALTH IMPROVEMENT

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD staff has the competencies/skills to advocate effectively for public health policy	<u>1</u>	<ul style="list-style-type: none"> ▪ Schedule of staff training on policy/advocacy development, copy of training, or list of trainings staff attended ▪ Directory of potential policy partners ▪ Community health assessment and plan showing populations at risk, differences in health status among various population groups, health disparities ▪ LHD annual reports presenting issues of special populations and root causes of health
2. LHD maintains a directory of potential policy partners	<u>0</u>	
3. LHD engages community partners in policy development process	<u>1</u>	
4. LHD conducts advocacy for local, state, and national policies and legislation that protect and promote the public’s health	<u>1</u>	
5. LHD develops a legislative strategy to reflect community needs and priorities	<u>1</u>	

<p>6. Constituency support is built around the LHD legislative agenda</p> <p style="text-align: right;"><u>1</u></p>		<p>problems</p> <ul style="list-style-type: none"> ▪ Special reports on health disparities ▪ Grant applications targeted at programs to reduce disparities ▪ Written summary or meeting minutes of governing body's approval of resources to address disparities ▪ Meeting attendance list showing participation in local committees working on community development or environmental issues, etc. ▪ Document that LHD engages local partnerships, state and national associations in advocacy/policy development ▪ Documentation of meetings or contact with state or local legislators (e.g. keep copy of electronic form letters)
--	--	--

Comments regarding non-contract entities providing services for this focus area above.

STANDARD V-C. Engage in LHD strategic planning to develop a vision, mission, and guiding principles that reflect the community's public health needs, and to prioritize services and programs.

FOCUS: LHD ROLE IN IMPLEMENTING COMMUNITY HEALTH IMPROVEMENT PLAN		
Operational Definition Indicators	Score	Illustrative Evidence
1. LHD leadership recognizes need for strategic planning	<u>2</u>	<ul style="list-style-type: none"> ▪ Organizational Capacity Self-Assessment (e.g., using APEX/PH Part I) ▪ Organizational strategic plan document or documentation of strategic priorities ▪ Annual budget forecast ▪ LHD mission or guiding principles statement ▪ Meeting minutes or agendas
2. LHD allocates resources for strategic planning	<u>2</u>	
3. LHD staff has expertise to lead and facilitate the strategic planning process	<u>1</u>	
4. LHD conducts a formal strategic planning process that considers its mission, vision and role in the community in relation to the assurance of the ten essential public health services	<u>2</u>	
5. LHD uses assessment data on community health	<u>2</u>	

problems and emerging health threats to develop annual program goals to develop policy		
6. LHD identifies new strategic opportunities for promoting public health activities	<u>2</u>	
7. The LHD widely disseminates its strategic plan and shares with the public and key stakeholders.	<u>2</u>	
8. LHD develops or updates the agency strategic plan every 24 months.	<u>2</u>	

Comments regarding non-contract entities providing services for this focus area.

ESSENTIAL SERVICE VI: Enforce public health laws and regulations

STANDARD VI-A. Review existing laws and regulations and work with governing bodies and policymakers to update them as needed

FOCUS: REVIEW AND MODERNIZE PUBLIC HEALTH AUTHORITY

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has legal expertise available to assist in the review of laws and regulations	<u>3</u>	<ul style="list-style-type: none"> ▪ Dates of any formal code review by the County Board or City Council ▪ Review of compliance of the local jurisdiction with state laws and regulations ▪ Minutes from meetings with policymakers on keeping public health laws up-to-date ▪ Participation in legislative committees of one of the local public health administrators associations ▪ List of access to legal counsel ▪ Dates of and written procedure for systematic planned review of local ordinances
2. The LHD, with the participation of its governing body, reviews policies and procedures within its existing legal scope of authority on a regular and periodic basis	<u>2</u>	
3. LHD evaluates the need for changes in rules, regulations, and ordinances	<u>2</u>	
4. LHD identifies its legal authority to develop, implement and enforce public health policy.	<u>2</u>	
5. LHD and governing body drafts modifications and/or formulations of laws and regulations.	<u>2</u>	
6. LHD uses a model public health emergency act in reviewing the local public health authority for managing emergencies	<u>2</u>	
7. LHD applies knowledge of disease trends, best	<u>2</u>	

practices and current public health science to legal reviews		
8. LHD and governing body inform policy makers of needed statutory and regulatory updates	<u>2</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD VI-B Understand existing laws, ordinances, and regulations that protect the public’s health.

FOCUS: LINK LHD PRACTICE TO EXISTING LAW AND REGULATION IN AN APPROPRIATE WAY

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has legal and program planning expertise available to assist in the review of laws and regulations.	<u>2</u>	<ul style="list-style-type: none"> ▪ Dates of any formal code review by the County Board of City Council ▪ Review of compliance of the local jurisdiction with state laws and regulations ▪ Minutes from meetings with policymakers on keeping public health laws up-to-date ▪ Participation in legislative committees of one of the local public health administrators associations ▪ List of access to legal counsel ▪ Dates of and written procedure for systematic planned review of local ordinances
2. LHD studies laws and identifies public health issues that can only be addressed through laws.	<u>1</u>	
3. LHD understand the intent of law and regulations with policy makers, legal counsel and other legislative bodies	<u>1</u>	
4. LHD reviews its programs to determine whether program changes are needed to better carry out legal mandates	<u>2</u>	
5. LHD identifies organizations with regulatory and enforcement authority.	<u>2</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD VI-C Educate individuals and organizations on the meaning, purpose, and benefit of public health laws, regulations, and ordinances and how to comply

FOCUS: COMMUNICATION AND EDUCATION ON HOW TO COMPLY WITH LAWS

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD staff is competent to provide education to regulated entities.	<u>1</u>	<ul style="list-style-type: none"> ▪ Trainings held for regulated entities (e.g. restaurants) ▪ Job descriptions of inspectors indicating education is part of their performance expectations ▪ Inspection case notes indicating education provided at time of inspection ▪ Formal, intentional education process incorporated into regulatory practice and documented in annual reports, inspection reports, etc.
1. LHD makes written policies, local ordinances, administrative code, and enabling laws accessible to the public	<u>1</u>	
2. LHD provides appropriate education to regulated facilities at the time of inspection.	<u>0</u>	
3. LHD invites regulated entities to education programs on new and/or updated regulations as appropriate.	<u>1</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD VI-D Monitor, and analyze over time, the compliance of regulated organizations, entities, and individuals.

FOCUS: TRACKING AND UNDERSTANDING PATTERNS OF COMPLIANCE WITH REGULATION

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has a system to track compliance records over time by each regulated organization.	<u>1</u>	<ul style="list-style-type: none"> ▪ Updated lists of regulated entities in the jurisdiction ▪ LHD Quality Assurance reports with summaries of most critical violations and most frequently-occurring violations ▪ Violations trends report examining level of violations over time in the jurisdiction ▪ Violations trends report examining level of violations over time by regulated entity
2. LHD staff is capable of analyzing data trends over time	<u>1</u>	
3. The LHD conducts inspections of regulated entities as appropriate (e.g., CD, animal control, environmental health) and monitors compliance	<u>1</u>	
4. LHD evaluates a selected number of enforcement actions each year to determine compliance with and effectiveness of enforcement procedures	<u>1</u>	
5. LHD conducts analysis of complaints, violations and enforcement activities to determine patterns, trends and latent problems at least annually	<u>0</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD VI-E Conduct enforcement activities.

FOCUS: COMPETENT AND FAIR ENFORCEMENT ACTIONS

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD workforce is skilled in enforcement procedures and credentialed as appropriate	<u>0</u>	<ul style="list-style-type: none"> ▪ Timeframes and frequencies of formal enforcement activities ▪ Enforcement intervention reports, including administrative interventions and legal interventions ▪ LHD annual report summarizing enforcement activities by type. ▪ Quality assurance activities incorporated into all regulatory activities
1. LHD uses a risk analysis method (i.e., identify restaurants with frequent violations) and a work plan to guide the frequency and scheduling of inspections of regulated facilities	<u>0</u>	
2. Written procedures and protocols for conducting enforcement actions are maintained.	<u>0</u>	
3. LHD routinely conducts enforcement activities according to procedures and protocols and rules are applied consistently.	<u>0</u>	
4. LHD promptly conducts enforcement activities needed in response to an emergency	<u>1</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD VI-F. Coordinate notification of violations among other governmental agencies that enforce laws and regulations that protect the public’s health.

FOCUS: NOTIFY OTHER GOVERNMENT AGENCIES OF ENFORCEMENT VIOLATIONS

Operational Definition Indicators	Score	Illustrative Evidence
1. Rapid communication capability can be demonstrated between the LHD and other enforcement entities	<u>2</u>	<ul style="list-style-type: none"> ▪ A chart or map of government agencies with enforcement responsibilities and contact information ▪ File/log of “inter-organizational” notifications
2. LHD has a comprehensive knowledge of other agencies involved in enforcement in the protection of the public health	<u>2</u>	

3. LHD develops and executes communication protocols for the notification of other enforcement agencies

2

- with back-up notification forms
- Procedures for inter-agency communication
- Memorandum of Understanding or other formal written inter-agency agreements

Comments regarding non-contract entities providing services for this focus area above

ESSENTIAL SERVICE VII: Help People receive health services

STANDARD VII a. Engage the community to identify gaps in culturally competent, appropriate, and equitable personal health services, including preventive and health promotion services, and develop strategies to close the gaps.

FOCUS: COMMUNITY-ORIENTED PROGRAM PLANNING

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD staff has a working understanding of access issues	<u>3</u>	<ul style="list-style-type: none"> ▪ Program assessments and plans, (e.g. HIV plans, MCH plans) ▪ Community forums report identifying access issues ▪ Community Health Assessment that identifies cultural competency and access as issues or community priorities ▪ Risk factor and other community surveys, including consumer satisfaction surveys, every two years ▪ Surveys targeted to special population groups, such as Hispanic populations ▪ Staff have education and/or training in program planning and community development methods and/or staff have conducted program planning or community development activities (e.g. Program staff have gone through MAPP training).
2. LHD staff are competent in program planning and community development methods	<u>2</u>	
3. LHD engages a diverse set of community partners, representing communities of color, tribal representatives and specific populations, to identify program gaps and barriers	<u>3</u>	
4. LHD, in partnership with community partners, interprets qualitative and quantitative information on program gaps, developed through surveys, focus groups, interviews or other means of primary data collection.	<u>2</u>	
5. LHD uses criteria periodically to evaluate access, quality, appropriateness and effectiveness of preventive and personal health services in the community.	<u>1</u>	
LHD identifies community health and prevention priorities to reduce access barriers every five years.	<u>1</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD VII-B Support and implement strategies to increase access to care and establish systems of personal health services, including preventive and health promotion services, in partnership with the community

FOCUS: PREVENTION AND PERSONAL HEALTH CARE SYSTEM BUILDING

Operational Definition Indicators	Score	Illustrative Evidence
1. A plan is in place for prevention and health promotion which identifies efforts to link public and private partnerships into a network of personal health and prevention services	<u>2</u>	<ul style="list-style-type: none"> ▪ Partnership meeting notes on implementation strategies ▪ Memorandum of Understanding ▪ Subcontracts in the community to implement services ▪ Community planning processes/plans ▪ Grant applications by members of community partnerships ▪ Letters of support for grants to other community agencies ▪ Community assessment data demonstrates an increase in access to care.
2. LHD maintains the capacity to provide health care services when local needs and authority exist, and the appropriate agency capacity and adequate additional resources can be secured.	<u>2</u>	
3. LHD convenes or participates in a collaborative process with community health care providers, social services organizations, and community stakeholders to coordinate service delivery and to reduce barriers to accessing primary and preventive services.	<u>3</u>	
4. LHD develops and implements strategies to increase utilization of public health programs and services	<u>3</u>	
5. LHD, in partnership with other community agencies, identifies gaps in access to critical health services through analysis of the results of periodic surveys and other assessment information.	<u>3</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD VII-C Link individuals to available, accessible personal health care providers (i.e., a medical home).

FOCUS: INDIVIDUAL-FOCUSED LINKAGES TO NEEDED CARE

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD maintains a current inventory of available personal health care resources	<u>3</u>	<ul style="list-style-type: none"> ▪ Reports on outreach and case management services

2. LHD uses a tracking system for health care referrals	<u>3</u>	<ul style="list-style-type: none"> ▪ Logs of referrals to care and/or reports from referral tracking system. ▪ Inventory of safety-net programs providers ▪ FQHC's operated by LHD or LHD an integral partner with FQHC ▪ Minutes of community meetings addressing concerns about outreach and/or tracking
3. LHD engages indigenous lay health advocates for outreach to special populations in need of health care.	<u>2</u>	
4. LHD provides community outreach and linkage services	<u>3</u>	
5. LHD disseminates or makes referrals to a current, comprehensive list of community health and wellness resources.	<u>4</u>	
6. LHD enrolls or links to enrollment agents potential beneficiaries in Medicaid or Medical Assistance Programs	<u>4</u>	
7. LHD informs the public, through a variety of methods, about services and resources available through LHD to reduce specific barriers to access to care	<u>4</u>	

Comments regarding non-contract entities providing services for this focus area above.

ESSENTIAL SERVICE VIII: Maintain a competent public health workforce

STANDARD VIII. A. Recruit, train, develop, and retain a diverse staff.

FOCUS: OVERALL HUMAN RESOURCES FUNCTION/ WORKFORCE CAPACITY

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has formally organized human resources function.	<u>3</u>	<ul style="list-style-type: none"> ▪ APEX Part I - Organizational Capacity Self-Assessment ▪ Organizational assessment within a larger agency strategic plan ▪ LHD organizational chart that includes the functional elements of the organization and their relationship to each other ▪ Job descriptions with minimum qualifications for each position ▪ Public Health Competencies incorporated into all LHD job descriptions
2. LHD has policies that promote and facilitate staff access to training	<u>4</u>	
3. LHD has a non-discriminatory employment policy	<u>4</u>	
4. LHD develops, uses, and revises job standards and position descriptions.	<u>3</u>	
5. LHD determines needed competencies, composition, and size of its workforce and seeks job applicants to fill those needs	<u>4</u>	

6. LHD periodically assesses its capacity (staff size, staff education and experience requirements, financial resources, and administrative capacity) in relation to the needs of the population it serves.	<u>3</u>	<ul style="list-style-type: none"> ▪ Written plans or policies regarding staff recruitment, selection, development, and retention ▪ Affirmative action plan ▪ Statement on equal opportunity
7. LHD conducts periodic studies of workforce needs and the effect on critical health services.	<u>2</u>	
8. LHD provides new employee orientation, employee-in-service and continuing education experiences where appropriate.	<u>4</u>	
9. LHD provides for staff training in cultural sensitivity and cultural competency.	<u>3</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD VIII-B Evaluate LHD staff members' public health competencies, and address deficiencies through continuing education, training, and leadership development activities.

FOCUS: PUBLIC HEALTH COMPETENCIES OF EXISTING WORKFORCE

Operational Definition Indicators	Score	Illustrative Evidence
1. A learning management system is in place to organize competency assessments and training and educational opportunities to address deficiencies	<u>3</u>	<ul style="list-style-type: none"> ▪ Report on annual reassessment of all staff competency levels and training needs ▪ Performance evaluations including worker objectives and continuing education and training plans, based in part on worker self-assessments ▪ LHD tracking system for staff participation in training and education ▪ Written policy on staff development ▪ LHD training plan based on self-assessment data ▪ Staff training and development plans ▪ List of LHD staff who have participated in workforce development activities including web-casts, online trainings, workshop etc. and list of these events
2. Training and leadership opportunities are available.	<u>4</u>	
3. LHD assesses its staff members to identify deficiencies in knowledge, skills and authority; and remedial action is taken when required.	<u>3</u>	
4. LHD provides incentives for the workforce to pursue education and training	<u>4</u>	
5. LHD provides opportunities for continuing education, training,	<u>4</u>	
6. LHD provides opportunity for leadership development for its staff	<u>4</u>	

7. LHD encourages or requires relevant certification and credentialing programs for individuals, not otherwise licensed or monitored by the state and whose activities can affect the health of the public	<u>4</u>	
8. LHD assures that each staff member has attended training within the past 24 months to maintain competency.	<u>4</u>	
9. LHD provides a coordinated program of continuing education for staff which includes attendance at seminars, workshops, conferences, in-service training, and/or formal courses to improve employee skills and knowledge in accordance with their professional needs	<u>4</u>	
10. LHD supports staff conference attendance and peer exchange opportunities	<u>4</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD VIII- C Provide practice- and competency based educational experiences for the future public health workforce, and provide expertise in developing and teaching public health curricula, through partnerships with academia.

FOCUS: DEVELOPING THE FUTURE WORKFORCE

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has partnership agreements in place with universities, schools or programs of public health and/or colleges to enrich public health practice and academic settings	<u>1</u>	<ul style="list-style-type: none"> ▪ Internships/preceptorships at the LHD for students at multiple levels (e.g. high school, college and graduate school) ▪ Guest lectures for public health classes ▪ List of LHD staff that have served as faculty (e.g. making presentations) at conferences, workshops, trainings, or school career orientation programs
2. LHD partners with academic institutions to provide clinical sites for training programs (e.g. internships) and for joint appointments for its staff.	<u>1</u>	
3. LHD implements plans for developing training and research focused interactions with academic institutions, including teaching courses, and faculty exchanges.	<u>0</u>	
4. LHD provides field training or work-study experiences for students enrolled in institutions of higher education.	<u>1</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD VIII-D Promote the use of effective public health practices among other practitioners and agencies engaged in public health interventions.

FOCUS: EFFECTIVE PUBLIC PRACTICED BY EXTERNAL WORKFORCE

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has agreements in place with public health systems partners for workforce assessment, training and professional education.	<u>0</u>	<ul style="list-style-type: none"> ▪ Presentations at community groups ▪ Annual reports to Board of Health on basic evaluation of programs, target groups, reach into the population at risk ▪ Meeting notes indicating LHD communication of best practices with other public health practitioners ▪ Consultations with other agencies on effective public health practices are documented ▪ Presentations at conferences ▪ Participation on advisory committees developing best practices ▪ Participation in Grand Rounds at local hospitals with physician committees ▪ Agreements with partner providers LHD makes presentations at public health and health care conferences
2. LHD shares best public health practices with community partners at meetings in the community (e.g. hospital meetings to plan a community health promotion initiative, Chamber of Commerce meetings to promote workplace wellness, etc.)	<u>2</u>	
3. LHD makes presentations at public health and health care conferences	<u>0</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD VIII-E Provide the public health workforce with adequate resources to do their jobs

FOCUS: ADEQUATE RESOURCES FOR JOB PERFORMANCE

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has identified funding sources for workforce job support activities	<u>4</u>	<ul style="list-style-type: none"> ▪ LHD budget has job support line items (e.g. basic office supplies and equipment,

2. LHD provides up-to-date computer hardware, software and internet access for each staff member	<u>4</u>	maintenance, provisions for a safe work environment, workforce safety, violence prevention, etc.) <ul style="list-style-type: none"> ▪ Inventory of computer and other equipment to assist staff in efficiently carrying out work tasks
3. LHD routinely makes public health and discipline-specific journals available for staff to stay updated in the field	<u>4</u>	

Comments regarding non-contract entities providing services for this focus area above.

ESSENTIAL SERVICE IX: Evaluate and improve programs

STANDARD IX. A. Develop evaluation efforts to assess health outcomes to the extent possible.

FOCUS: OVERALL LHD EVALUATION STRATEGY FOCUSES ON COMMUNITY OUTCOMES

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has data on community health outcomes and risk factors readily available for evaluation purposes	<u>3</u>	<ul style="list-style-type: none"> ▪ Community health assessment examine a wide scope of health outcomes and inform future service delivery ▪ Examples of monitoring health outcomes that result in redirected program efforts ▪ Annual reviews of progress in reaching outcome and impact (addressing risk factors) objectives ▪ Annual report cards on progress in improving health outcomes
2. LHD staff or external evaluation expertise is in place	<u>2</u>	
3. LHD has assigned responsibility for evaluation within the organization	<u>3</u>	
4. LHD has plans in place to reduce specific gaps in access or make other improvements in public health services	<u>3</u>	
5. LHD develops and executes an internal policy to guide its overall evaluation efforts, including frequency and scope of program evaluations, organizational evaluations, use of health outcomes as benchmarks for evaluations	<u>2</u>	
6. LHD conducts evaluation activities that include an analysis of local data (e.g., analyzing age-specific participation in preventive services) with established community health goals, objectives and performance measures.	<u>2</u>	

7. LHD uses community health outcome targets (e.g. Health People 2010) as benchmarks for evaluating the effectiveness of public health services	<u>2</u>	
8. LHD assures that population-based services are provided according to established standards and guidelines	<u>3</u>	
9.		

Comments regarding non-contract entities providing services for this focus area above.

STANDARD IX-B Apply evidence-based criteria to evaluation activities where possible

FOCUS: EVIDENCE- BASED METHODOLOGY FOR EVALUATION

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has evaluation expertise readily available	<u>2</u>	<ul style="list-style-type: none"> ▪ Protocol(s) for LHD program evaluation describing reasonable evaluation frameworks, including use of externally-developed standards, benchmarks, baseline data ▪ References for research, such as literature search, or use of experts in evaluation process ▪ Use of <i>CDC's Framework for Program Evaluation</i> ▪ Documentation that evidence based methodology has been applied
2. LHD uses an acceptable evaluation framework that connects the public health intervention with health outcomes produced, based on the collection and use of evidence	<u>2</u>	
3. LHD periodically evaluates its key processes of service delivery for efficiency and effectiveness, using established criteria (e.g., from research literature, management literature, etc.)	<u>1</u>	
4. LHD makes formal efforts to identify best practices or benchmarks for evaluation purposes.	<u>1</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD IX-C Evaluate the effectiveness and quality of all LHD programs and activities and use the information to improve LHD performance and community health outcomes.

FOCUS: EVALUATE LHD PROGRAMS

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has a systematic process for assessing consumer	<u>1</u>	<ul style="list-style-type: none"> ▪ Reports, summaries of analysis, or meetings

and community satisfaction with agency services		
2. LHD monitors program performance measures and analyzes data to document the progress toward goals and grant/funding requirements	<u>3</u>	minutes or materials that demonstrate program monitoring activities <ul style="list-style-type: none"> ▪ Report of an evaluation findings ▪ Program review documents that demonstrate LHD compliance with applicable professional and regulatory standards ▪ Use of a performance management system to improve the quality of programs ▪ References for research, such as literature search, or use of experts in evaluation process ▪ Documentation that evaluation has resulted in program modification
3. LHD evaluates the quality of clinical and preventive population based programs	<u>3</u>	
4. LHD program evaluations identify need for change in policies and/or programs.	<u>3</u>	
5. LHD employs a quality assurance/quality improvement process that uses evaluation findings	<u>2</u>	
6. LHD uses data on customer needs and service delivery to improve processes and/or in the design and delivery of new programs/services	<u>2</u>	
7. LHD changes its program activities to improve effectiveness, based on evaluation findings	<u>2</u>	

Comments regarding non-contract entities providing services for this focus area above

STANDARD IX-D Review the effectiveness of public health interventions provided by other practitioners and agencies for prevention, containment, and/or remediation of problems affecting the public’s health, and provide expertise to those interventions that need improvement.

FOCUS: EXTERNAL EVALUATION OF OTHER’S PROGRAMS

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD maintains data systems for capacity, availability, quality, cost and utilization of health services	<u>3</u>	<ul style="list-style-type: none"> ▪ Written protocols or summary of CHP process, indicating level of coordination among community organizations in providing services that improve the health of the public ▪ Monitoring of progress of local public health system towards meeting community health objectives as stated in the community health plan ▪ Examples of reviews of the effectiveness of
2. Agreements between LHD and external agencies for evaluation are in place	<u>2</u>	
3. LHD provides consultation and technical assistance on program implementation and evaluation of prevention services provides by other community agencies	<u>2</u>	
4. LHD evaluates the accessibility, quality, and	<u>2</u>	

effectiveness of personal health services		community agencies and coordination with LHD to improve service delivery
5. LHD assures that a systematic process for assessing consumer and community satisfaction with external agency services is in place.	<u>1</u>	
6. LHD assures that a systematic process for assessing consumer and community satisfaction with external agency services is in place.	<u>Duplicate?</u>	

Comments regarding non-contract entities providing services for this focus area above.

ESSENTIAL SERVICES X: Contribute to and apply the evidence base of public health

STANDARD X a. When researchers approach the LHD to engage in research activities that benefit the health of the community,

- i. Identify appropriate populations, geographic areas, and partners;**
- ii. Work with them to actively involve the community in all phases of research;**
- iii. Provide data and expertise to support research; and,**
- iv. Facilitate their efforts to share research findings with the community, governing bodies, and policymakers.**

FOCUS: PARTICIPATE IN RESEARCH ACTIVITIES

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has access to the resources to participate in research (e.g., data and expertise)	<u>3</u>	<ul style="list-style-type: none"> ▪ LHD policy on data sharing ▪ Participation in public health surveys ▪ Collecting data that can be used in research (e.g. West Nile data) ▪ Relationship with a university, where available, such as meeting notes, agendas etc.
2. LHD has policies which endorse participatory research and ensuring the rights of participants in local public health research programs.	<u>1</u>	
3. LHD partners with academic/research institutions of higher education that are interested in conducting public health research. (e.g., provide data, content expertise)	<u>1</u>	
4. LHD proposes public health issues for research agendas, as appropriate.	<u>0</u>	
5. LHD convenes community members and key	<u>1</u>	

community partners, as appropriate, to identify opportunities for community participatory research that would benefit the community

Comments regarding non-contract entities providing services for this focus area above.

STANDARD X- B Share results of research, program evaluations, and best practices with other public health practitioners and academics

FOCUS: DISSEMINATE RESEARCH FINDINGS

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has access to expertise to evaluate current research and participate in research dissemination activities	<u>2</u>	<ul style="list-style-type: none"> ▪ Presentations at community groups ▪ Annual reports to Board of Health on basic evaluation of programs, target groups, reach into the population at risk ▪ Documentation of LHD communication of best practices with other public health practitioners ▪ Documentation of consultations with other agencies on effective public health practices
1. LHD disseminates research findings to public health colleagues	<u>3</u>	
2. LHD disseminates research findings to the community, partners and policy makers.	<u>2</u>	
3. LHD provides expertise, based upon research into innovative solutions, to elected officials and community organizations involved in developing and analyzing public policy and in planning implementation of population-based strategies.	<u>2</u>	

Comments regarding non-contract entities providing services for this focus area above.

STANDARD X-C Apply evidence-based programs and best practices where possible

FOCUS: APPLY RESEARCH RESULTS IN LHD ACTIVITIES

Operational Definition Indicators	Score	Illustrative Evidence
1. LHD has access to expertise to evaluate current	<u>1</u>	<ul style="list-style-type: none"> ▪ Inventory of intervention strategies by source

research and participate in research translation activities.		<p>(e.g. evidence-based approaches and/or best practices from grants, CDC's Guide to Community Preventive Services, Guide to Clinical Preventive Services, etc.)</p> <ul style="list-style-type: none"> ▪ Meeting notes documenting participation a Best Practices Committee ▪ Program/policy examples from LHD that are based on best practices (e.g. State-determined best practice) ▪ Written summary or protocol of how LHD evaluates research for applicability to practice
2. LHD seeks information about applicable evidence-based programs before implementing interventions	<u>2</u>	
3. LHD evaluates research efforts for applicability in practice	<u>1</u>	
4. LHD implements, on a priority basis, newly developed and innovative strategies, methodologies, programs, and projects, which have been demonstrated to be effective in improving public health.	<u>2</u>	
5. LHD provides technical assistance to external organizations in applying relevant research results.	<u>1</u>	

Comments regarding non-contract entities providing services for this focus area above.

OREGON DEPARTMENT OF HUMAN SERVICES
 PUBLIC HEALTH SERVICES
BUDGET PROJECTION
FOR FAMILY PLANNING ONLY
 For the Period July 1, 2008 - June 30, 2009

Agency: Morrow County Estimated Budget

A. Revenues	Estimate	Total
Program Income		\$2,700
1. Client Fees – Self-Pay	\$1,000.00	
2. Donations	\$200.00	
3. Third Party Insurance Reimbursement	\$1,500.00	
Other Revenue:		\$147,300
State FP Grant	\$23,031.00	
Medicaid / OHP	\$4,000.00	
FPEP	\$24,000.00	
County General Funds	\$95,969.00	
Other (please identify) Prgm Reimbursements	\$300.00	
Total Revenue		\$150,000

B. Expenditures		Total
1. Personal Services (Salaries & Benefits)		\$95,000
2. Services and Supplies		\$55,000
3. Capital Outlay		\$0
Total Expenses		\$150,000

Estimated expenditures for the Family Planning Program should reflect the total cost of the program. It is not necessary to separate Title X and FPEP expenses.

This project budget will be used to meet the Title X Grant application requirement.

Sheree Smith 541/676-5421

 PREPARED BY PHONE

Sheree Smith, Public Health Director 2/15/08

 AUTHORIZED AGENT DATE

APPENDIX

Local Health Department: Morrow County
Plan A - Continuous Quality Improvement: Improve Immunization Coverage
Fiscal Years 2008-2010

Year 1: July 2008 – June 2009				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results ¹	Progress Notes ²
A. Decrease percent of 24 mos Missed Shots.	1. Always obtain forecast prior to giving immun. 2. Give ALL indicated vaccinations at time of service unless parent refuses.	- Percentage of missed shots to be decreased to 10% by next year (2008 data with updated criteria).	To be completed for the FY 2009 Report	To be completed for the FY 2009 Report
B. Increase percent of 24-mos olds covered with DTaP 4.	1. Reminder sticker on Imm record reflective of minimal spacing. 2. Provide card with clinic day/hours. 3. Review clinic day/hour info with WIC partners.	-Increase in percent of DTaP 4 to 72% at 24 mos of age by next year (2008 data).	To be completed for the FY 2009 Report	To be completed for the FY 2009 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 2009 – June 2010				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
A.Cont to decrease percent of 24 mos Missed Shots.			To be completed for the FY 2010 Report	To be completed for the FY 2010 Report
B. Cont to Increase percent of 24-mos olds covered with DTaP 4.			To be completed for the FY 2010 Report	To be completed for the FY 2010 Report

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

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

Year 3: July 2010 – June 2011				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
A. Cont to decrease percent of 24 mos Missed Shots.			To be completed for the FY 2011 Report	To be completed for the FY 2011 Report
B. Cont to increase percent of 24-mos olds covered with DTaP 4.			To be completed for the FY 2011 Report	To be completed for the FY 2011 Report

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

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

Local Health Department: Morrow County
Plan B - Chosen Focus Area: ALERT Promotion
Fiscal Years 2008-2010

Year 1: July 2008 – June 2009				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results ¹	Progress Notes ²
A Increase promotion of ALERT Immunization Registry thereby increasing usage by community partners.	1. Continue follow up with schools and other community partners such as Daycares and Pre-schools. 2. Offer information, education, training and/or assistance as needed.	• Increase the use of the ALERT registry based on numbers of users for Morrow County.	To be completed for the FY 2009 Report	To be completed for the FY 2009 Report
B.			To be completed for the FY 2009 Report	To be completed for the FY 2009 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 2009 – June 2010				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results ¹	Progress Notes ²
A. Continue to increase promotion of ALERT Immunization Registry thereby increasing usage by community partners.			To be completed for the FY 2010 Report	To be completed for the FY 2010 Report
B.			To be completed for the FY 2010 Report	To be completed for the FY 2010 Report

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

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

Year 3: July 2010 – June 2011				
Objectives	Methods / Tasks	Outcome Measure(s)	Outcome Measure(s) Results¹	Progress Notes²
A. Continue to increase promotion of ALERT Immunization Registry thereby increasing usage by community partners.	<ul style="list-style-type: none"> Continued communication with each of the schools to answer questions and provide needed supports to ensure success in using ALERT. 	<ul style="list-style-type: none"> Evidenced by the total number of schools using ALERT within the county. 	To be completed for the FY 2011 Report	To be completed for the FY 2011 Report
B.			To be completed for the FY 2011 Report	To be completed for the FY 2011 Report

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

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

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 assistance as needed to increase usage.	• Increase the total number of schools using ALERT based on comparison of current users.	1. Contact was made with each school during primary review to encourage the use of ALERT. 2. Information was provided regarding how to participate in ALERT.	There seemed to be a greater number of schools utilizing ALERT to update or check immunization status for the primary review process.
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) Results¹	Progress Notes²
A. Continue to increase the use of ALERT within the school system throughout the county.	<ul style="list-style-type: none"> Follow-up contact with each of the schools regarding the use of ALERT. 	<ul style="list-style-type: none"> Continued increase in the number of schools utilizing ALERT compared with the previous FY. 	We have not yet gone to each of the schools individually. We continue to encourage staff inquiring about Imm status to use the Alert system. We continue to note an overall increase in use although it has not been as much as we had hoped.	Not surprisingly, the greatest increase in usage was noted during Primary Review. School staff requesting vaccine history were directed to the Alert system and assisted in the utilization process. We also encouraged Daycare staff to use this same technology.
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) Results¹	Progress Notes²
A. All of the schools will be utilizing ALERT by June 2008.	<ul style="list-style-type: none"> Continued communication with each of the schools to answer questions and provide needed supports to ensure success in using ALERT. 	<ul style="list-style-type: none"> Evidenced by the total number of schools using ALERT within the county. 	Although we have had phone contact with each of the schools, we did not visit them on site. We have continued to provide information and guidance in accessing the ALERT system which was especially helpful throughout the primary review process.	ALERT usage was most evident during Primary Review. We noted a decrease in phone call inquiry from school staff regarding immunization status and a decrease in incomplete immunization histories with fewer exclusions.
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).	FY 2004 missed shots rate at 11.4%. Goal to decrease to 10%. FY 2005 missed shot rate now at <u>6.3%</u>!	1. Education of staff at Immum. Conf. 2005. Staff then began to educate parents re “best practice” 2. All indicated vaccines given at time of service unless parent refuses.
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).	FY 2004 Hep B dose #3 at 24 mos rate at 79.6% FY 2005 Hep #3 at 24 mos now at <u>89.9%</u>!	1. Reminder stickers reflect minimal spacing. 2. Card with clinic days and hours made and distributed to clients. 3. WIC given clinic days and hours (laminated cards) for referral information.

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) Results¹	Progress Notes²
A. Decrease percent of missed shots and /or opportunities.	<ol style="list-style-type: none"> 1. Evaluation of staff offering of all indicated vaccine at each contact. 2. Evaluation of acceptance of all indicated vaccines by parent, at time of service. 	<ul style="list-style-type: none"> • Percentage of missed doses to be 5% or less at the time of the next Annual Report. 	<p>We were not able to meet our goal of 5% for missed doses.</p> <p>FY 2006 missed shot rate has risen to our previous FY 2004 rate of 11%.</p>	<ol style="list-style-type: none"> 1. It is noted that the QA's listed in the beginning of the 2006 Annual Report notes that a change in the way missed shots are calculated may result in a slight increase in the missed shot rate. However, the overall increase was surprising as staff have tried very hard to give all shots due at the time of visit.. 2. Parents response has not seemed to be a huge barrier to shots.
B. Increase percent of Hep B dose # 3 by age 24 mos.	<ol style="list-style-type: none"> 1. Continuation of reminder sticker for minimal spacing placed on the outside jacket of the immunization card. 2. Cont. use of clinic day/hour card.. 3. Plan to touch base with WIC regarding cont. use of clinic day/hour info. 	<p>-Continue to increase percent of Hep B dose # 3 to 92%, by 24 mos of age per most recent data.</p>	<p>The projected percentage of Hep B # 3 for FY 2006 was 92% and that has been exceeded with a current 24 mos rate of <u>93%</u>.</p>	<ol style="list-style-type: none"> 1. Reminder stickers continue to reflect minimal spacing. 2. Card with clinic days and hours continues to be distributed to clients. 3. WIC continues to refer for immunizations and to provide clinic day/hour info.

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) Results¹	Progress Notes²
A. Continue to improve (decrease number) of missed doses.	<p>1. Continue to offer all indicated vaccines at time of service. This issue will also be revisited at staffings to discuss ways in which we can avoid or minimize missed opportunities.</p> <p>2. Continue to offer all shots due at each visit and evaluate parental acceptance at the time</p>	<ul style="list-style-type: none"> Percentage of missed opportunity as per most current data to be 7% or less. 	<p>We were unable to meet our goal of decreasing our percentage of missed opportunity. Note that the rate shown using 2006 criteria was the same (unimproved, but not worse). With 2007 criteria the official rate for FY 2007 has risen to <u>13%</u>.</p>	<p>We have experienced some changes in staffing and it has recently come to our attention that forecasts were not always done at the time the client presented for care resulting in the missed opportunities. This situation has since been remedied as every client now receives a forecast prior to immunization.</p>
B. Continue to increase the percent of Hep B dose # 3 received by 24 mos. of age.	<p>1. Continue to provide reminders of next dose due at minimal spacing.</p> <p>2. Cont. use of clinic cards for day/hours services available.</p> <p>3. Cont. use of cards/reminders per WIC.</p>	<p>-Continue to increase percentage of Hep B dose # 3 to 95%, at 24 mos of age as per most recent data.</p>	<p>The projected percentage of Hep B # 3 for FY 2007 was 95%. This goal has been met as the current Hep B #3 at 24 mos of age is <u>95%</u>.</p>	<p>We have continued to provide reminder stickers (with minimal spacing as needed), provide clinic cards with day and times noted, and continued to collaborate with WIC.</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 meet these objectives in the future.

