Strategic Plan for Preventing and Reducing Infectious Disease

Grays Harbor County

March 2008

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Statement of Agency Support

I have reviewed and approved this plan.

_____**Date**_____

Joan Brewster, Director
Grays Harbor County Public Health and Social Services Deptartment

Thank you to Karen Arbogast, Michelle Balter, Lisa Leitz, Marnie Schumacher, and Jody Wayman for their thoughtful and enthusiastic contributions to this planning effort.

Report prepared by Karolyn Holden

Purpose

This plan is intended to prioritize and direct the Department's specific and targeted efforts to prevent and reduce infectious disease.

Background

A Public Health Priority: Prevention and control of infectious disease is a cornerstone of public health practice. Basic measures such as sanitation, isolation, and immunization are the primary factors underlying the remarkable improvements in our quality and length of life over the past 100 years. These efforts have been central to the Department's efforts throughout its existence.

New Resources for Old Problems: In 2006, the Washington State legislature allocated $20 million to improve the state's public health system with the passage of Engrossed 2nd Substitute Senate Bill (E2SSB) 5930. The bill, which resulted in a $150,000 annual allocation for Grays Harbor County, specifies that the funds are to be used specifically to improve communicable disease prevention, investigation, and control, and to increase the level of protection provided to Washington's citizens through appropriate and timely immunization. A third priority, reduction of obesity, could also be addressed if resources allowed.

Statewide Performance Measures: Statewide performance measures and metrics were developed for these three priority areas through a collaborative effort across the public health system. These measures became the basis for the Department's planning to improve performance in immunization promotion and communicable disease prevention and response.

1. Increase the uptake of new and under-used child and adolescent vaccines; specifically focusing improvement efforts and reporting on varicella, rotavirus, human papilloma virus (HPV) and pediatric influenza.
2. Improve the timely, complete identification and standard, effective investigation of notifiable conditions per WAC 246-101.
3. Develop and implement effective community and health care system interventions to address obesity and its consequent burden of chronic disease. Interventions may target worksites, schools, communities or primary medical care.

The Department has determined that it has sufficient resources to address the first two performance measures in this funding period; therefore, performance measure three, related to obesity, will not be addressed in this plan.

Planning Method

The workgroup responsible for the creation of this plan included the three public health nurses who have been involved in clinical services and communicable disease surveillance, the clinical nursing supervisor, the reproductive health nurse practitioner, and the department's two public health nurse managers. The group considered a broad range of data, including the following, in its development.

- Key Health Indicators
- Notifiable conditions rates, recent trends, and epidemiology
- Access to related clinical services
- Current activities
- Barriers to improvement
- Opportunities and resources
- Forces of change

Common Challenges and Opportunities

A number of challenges were identified that had implications for both of the performance measures addressed in this plan.

- The number and proportion of patients of Hispanic ethnicity seeking reproductive health services (a proxy indicator for persons with limited English proficiency) has increased from 319 (12%) in 2002 to 391 (23%) in 2007.
- The number of TB skin tests offered through the RN clinic has increased in recent years (26 tests in 2003; 539 tests in 2007) following a decision by a major community provider to discontinue providing this service to non-patients.
- The number of "targeted" TB skin tests (those administered deliberately among populations at high risk of TB infection) have decreased during this period (139 in 2003; 34 in 2007).

- "Administrative" TB skin tests (those administered solely to meet labor or other administrative requirements) currently dominate the RN clinic schedule. The Department administered 506 TB skin tests to persons without any identified risk factors in 2007.
- The Department's appointment-scheduling program does not allow the flexibility to provide appointment slots of different length within the same clinic schedule. Appointment slots in the RN clinic are 30 minutes to accommodate the more complex services that are offered, which is far too long for administration of a TB skin test.
- An average of 13 TB skin tests per week were administered in 2007-08 YTD. At 30 minutes per test, and 30 minutes per read, this is an average of 13 hours per week (40% of the available 32.5 hours in the nurse schedule) that are consumed with TB skin testing appointments.
- There is often difficulty accommodating other needs in the clinic schedule in a timely manner. The RN clinic is regularly booked out 2 weeks in advance.
- All three public health nurses are using computer hardware that is inadequate for their business needs.
- Currently the clinical nursing supervisor and both public health nurse managers are involved in directing immunization and communicable disease-related work. The overlap in management and supervision across these functions presents a risk of miscommunication, confusion, and inconsistency.
- The Department's "Moving Grays Harbor" bi-monthly newspaper column will be expanding its topical focus and is a possible method to deliver public education on a variety of issues including vaccination and communicable disease.

Performance Measure #1: Immunizations

Significant Findings

- Key Health Indicators

  ☑ Rates of influenza immunization among Grays Harbor County citizens age 65 and older are significantly lower than the state average (62% vs. 69% in 2004-06).[i]

- Current Activities

  ☑ Currently, there are 20 contracted VFC providers in Grays Harbor County (19 active; 1 suspended).

  ☑ In 2007, the Department conducted 72 immunization provider site visits.

  ☑ In 2007, the Department conducted 6 VFC/AFIX assessments with contracted VFC providers.

  ☑ 9 local providers are using CHILD Profile in some way.

  ☑ 3 local providers are currently not carrying the full range of VFC-provided vaccines (varicella)

  ☑ There are currently two clinic sites offering gynecologic care in Grays Harbor County. Neither of them carry HPV vaccine. One has refused, the other has not been approached.

  ☑ There is currently one internal medicine clinic that is referring women to public health for HPV vaccination.

  ☑ In 2007, the Department administered:
  - 90 doses of varicella vaccine
  - 8 doses of rotavirus vaccine
  - 280 doses of HPV vaccine
  - 42 doses of pediatric influenza vaccine

  ☑ In 2007, VFC providers ordered/administered
  - 2505 doses of varicella vaccine
  - 589 doses of rotavirus vaccine
  - 1198 doses of HPV vaccine
  - 3702 doses of pediatric influenza vaccine

Barriers to Improvement

- Some provider offices lack the necessary computer hardware and internet access to support CHILD Profile participation.
- There are many competing messages and priorities for health care provider time and attention.
- Department policy has discouraged spending for incentives, food, etc. This puts us at a disadvantage in trying to engage providers and their staff.
- The immunization laptop for site visits is slow and unreliable.
- The current scope of practice for Medical Assistants prohibits the administration of oral medications, creating a barrier to administration of rotavirus vaccine in many offices.
- Lack of knowledge regarding reimbursement for vaccination services among some providers feeds the perception that vaccination services are cost-prohibitive for offices to provide.
- Typically school nurses promote compliance with immunization *requirements* instead of *recommendations.* This results in conflicting information being delivered to parents and does not optimize parental education opportunities.
- The number of immunizations recommended for adolescents makes appropriate preventive health care complicated to deliver.
- There is a potential for controversy in providing HPV vaccine at schools, because HPV is sexually transmitted.
- There are many competing messages and priorities for school staff.
- Parents may be reluctant to accept rotavirus vaccine because of the history of safety problems with the previous formulation.

Opportunities and Resources

- Sanofi-pasteur has an expert on how to bill immunization services and an ARNP who is a specialist in adolescent health care, including immunizations. These experts are available to provide training for health care providers in cooperation with public health.
- The health officer practices family medicine full-time and is able to easily access and communicate with local health care providers.

Forces of Change

- Providers will soon be required by DOH to place vaccine orders through CHILD Profile.
- There is a strong possibility that the ACIP will recommend universal vaccination for influenza among persons 6 months to 18 years of age in the very near future.

Analysis

- Over the past decade the number of vaccines recommended for routine use has increased significantly. Providing appropriate immunization services is increasingly complex.
- Turnover among provider office support staff presents a challenge in maintaining trained experts in immunization practice.
- Public health is directly involved in pediatric immunization in a very limited way. In 2007, less than 4% of the varicella, rotavirus, and pediatric flu vaccine doses ordered were ordered by public health.
- About 19% of HPV doses were ordered by public health. This and other adolescent vaccines are more susceptible than others to direct public health intervention due to partnership with schools and the population seen through reproductive health services.
- Interventions to improve uptake of underused vaccines will require a combination of strategies that include improving immunization practices among community providers as well as direct provision of immunization services.
- More public health nurse time to focus on provider education and assistance will be required to achieve progress toward established goals.

Goals and Objectives

After their review and analysis of the findings above, the planning group selected the following goals and objectives related to performance measure #1 for 2008.

Goal 1.1. Improve provider participation in CHILD Profile

Critical Influence	Key Partners
Local VFC providers and their office managers	CHILD Profile DOH Sanofi-Pasteur

Objectives

1.1.a. By 12-31-08 host a training targeting VFC provider office managers which features a CHILD Profile staff person demonstrating the various utilities of CHILD Profile. Offer a PC as a door prize (combined with billing in-service – see Objective 1.3.b).

1.1.b. By 4-30-08 develop a tool to assess each VFC provider's:

- Current use of CHILD Profile
- Current hardware access
- Current internet access
- Current practices in documenting childhood immunization
- Current practices in implementing an immunization recall system
- Storage capacity and practices

1.1.c. By 6-30-08 complete collection and analysis of data referenced above.

1.1.d. By 7-15-08 share results of assessment with DOH immunization program.

1.1.e. By 12-31-08, provide individualized follow-up with 6 VFC provider sites to increase utilization of CHILD Profile.

Goal 1.2. Identify provider-specific baseline levels of vaccine coverage by antigen via AFIX for all contracted VFC providers

Critical Influence
Local VFC providers

Objectives

1.2.a. By 4-30-08 develop a proposal for the use of incentives in improving immunization rates and present to Department management for review.

1.2.b. By 12-31-08 complete a CoCasa assessment for at least 6 VFC providers.

1.2.c. By 4-30-08, develop a plan to improve access to adequate computer hardware for primary immunization-outreach staff.

Goal 1.3. Increase provider awareness of underused vaccines (particularly in the arena of adult vaccines and reimbursement rates)

Critical Influence	Key Partners
Local VFC providers	Sanofi-Pasteur

Objectives

1.3.a. By 12-31-08 provide feedback using the AFIX system to 6 VFC providers.

1.3.b. By 12-31-08 provide an in-service for office managers regarding maximizing reimbursement for immunizations, including immunization of adults (combined with CHILD Profile training – see objective 1.1.a).

1.3.c. By 7-31-08 offer an in-service targeted to providers regarding reduction of missed opportunities for immunization, including adolescent immunizations. Target: minimum of 80% provider offices attending.

Goal 1.4. Partner with schools to improve immunization awareness and uptake.

Critical Influence	Key Partners
School nurses	Health care providers
School athletic directors	providing sports physicals

Objectives

1.4.a. By 6-15-08, develop a plan in collaboration with athletic directors and/or coaches from at least 3 school districts to offer adolescent immunization services on-site during sports physicals.

1.4.b. By 8-31-08, deliver appropriate vaccines to adolescents via at least 3 sports physical events.

1.4.c. By 6-15-08 meet with school nurses representing at least 3 districts to explore collaborating at conferences, open houses, orientations, etc to promote age-appropriate and optimal immunization.

Goal 1.5. Increase awareness of the need for adolescent vaccination among parents

Critical Influence	Key Partners
School nurses	Local media
Parents	Health care providers

Objectives

1.5.a. By 6-15-08 assess what materials school nurses are using to communicate with parents about immunization requirements.

1.5.b. By 9-30-08 identify and procure materials to provide to school nurses for use in communicating with parents about adolescent immunization requirements and recommendations.

1.5.c. By 5-31-08 develop a specific communications plan to promote immunizations throughout the remainder of 2008 and submit for inclusion in the Department's overall communications plan

Key Performance Indicators

In addition to measuring success at meeting the objectives above, the evaluation of the work described in this plan will be based on monitoring the following indicators related to immunization.

- ☑ The number of VFC providers using CHILD Profile
  Data source: CHILD Profile/DOH
  Baseline: 9 providers, very limited use; primarily export of billing data

- ☑ The number of doses of the four identified vaccines ordered by the Department
  Data source: DOH
  Baseline: varicella 90; rotavirus 8; HPV 280; influenza 42

- ☑ The number of doses of the four identified vaccines ordered by local VFC providers
  Data source: DOH
  Baseline: varicella 2505; rotavirus 589; HPV 1198; influenza 3702

Performance Measure #2: Communicable Disease

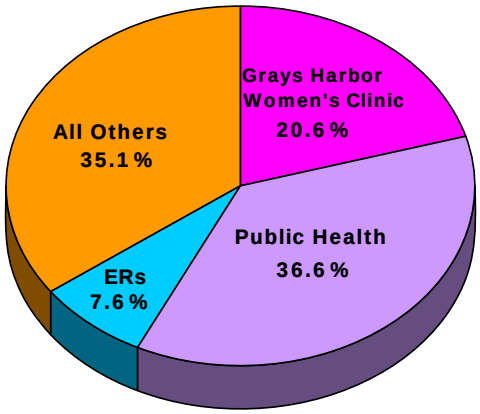
Significant Findings

- Key Health Indicators
  - ☑ The rate of reported chlamydia among the county's 15-24 year-old women is comparable to state average rates (2297 per 100,000 vs. 2234 per 100,000 in 2004-06).[ii]
  - ☑ The rate of documented treatment among reported chlamydia infections for this same population is significantly higher than the state average (97% vs. 93% in 2004-06).[ii]
- Notifiable conditions rates, recent trends, and epidemiology
  - ☑ Overview
    - o Chlamydia is the most commonly reported acute notifiable infectious disease (behind chronic viral hepatitis infection) in Grays Harbor County and across Washington.[iii],[iv]
    - o After chlamydia, genital herpes, gonorrhea, and campylobacter are the most frequently reported notifiable conditions among Grays Harbor County residents. During 2005-07, the Department reported an annual average of:
      - 146 cases of chlamydia
      - 15 cases of genital herpes (first outbreak)
      - 14 cases of gonorrhea
      - 10 cases of campylobacteriosis
      - A few cases each year of salmonellosis, tuberculosis, pertussis, giardiasis, hepatitis B, and HIV/AIDS.
    - o An average of 35 animal bites/bat exposures are investigated each year. As a result, an average of 2.5 individuals per year are recommended to receive rabies post-exposure prophylaxis.
  - ☑ Chlamydia
    - o Chlamydia is reported among young women aged 15-24 far more often than in any other group. Although young women are at higher physiologic risk of infection than older women if exposed, the discrepancy between young women and other populations is very likely due in part to the high incidence of asymptomatic infection and fact that young women are much

more likely to be screened for chlamydia than their older counterparts or males of any age.

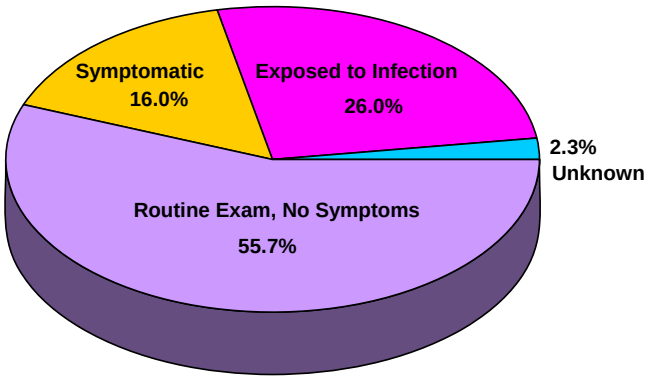
- The single largest reporter of chlamydia and other sexually transmitted infections among county residents is the Department's reproductive health clinic. In 2004-05, an average of 45% of total chlamydia reports were filed by the clinic. In 2006-07, this proportion decreased to an average of 33%.

Chlamydia Reports By Provider, Grays Harbor County, 2007



- Over half of reported chlamydia infections are detected as a result of routine screening of asymptomatic individuals.

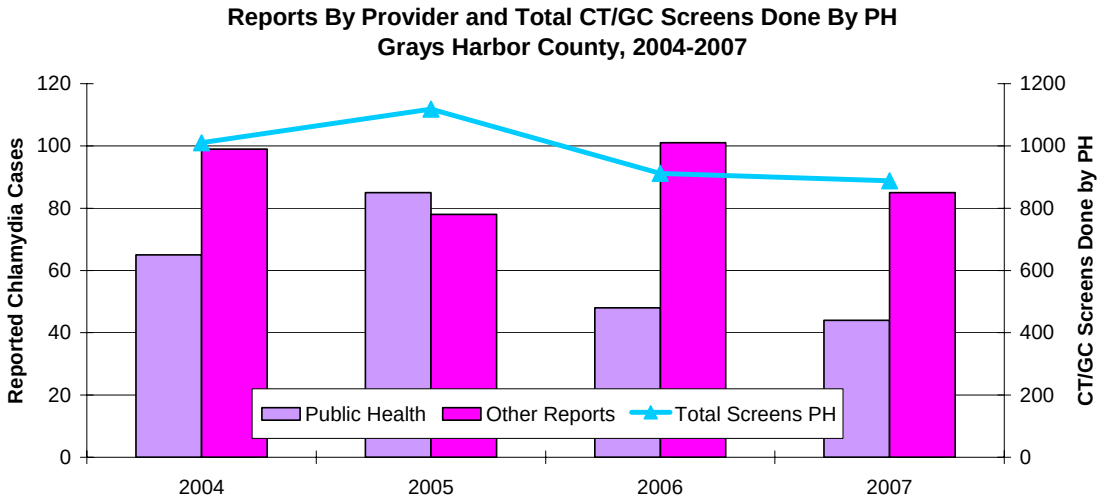
Chlamydia Reports By Reason for Exam, All Reporters 2007, Grays Harbor County



- The number of chlamydia infections being reported has declined over the past four years from an average of 164 in 2004-05 to 129 in 2006-07.

- Access to related clinical services

  ☑ The number of chlamydia infections reported by the Department's reproductive health clinic fell from 75 in 2004-05 to 48 in 2006-07. During that same period, the number of CT/GC screens done by the Department decreased from 1010 screens in 2004 to 888 screens in 2007. This is, in part, reflective of an overall drop in unduplicated clients seen through the family planning clinic; from 2187 in 2002 to 1593 in 2007.



  ☑ Take Charge eligibility rules exclude many at-risk teens from the program. This, along with fees for services that are currently passed on to the client, present a significant financial barrier to many persons at risk of STI.

  ☑ Medicaid will pay for STI screening services whether symptoms are present or not.

  ☑ Take Charge will pay for STI screening only if it is done as a routine part of a family planning annual visit.

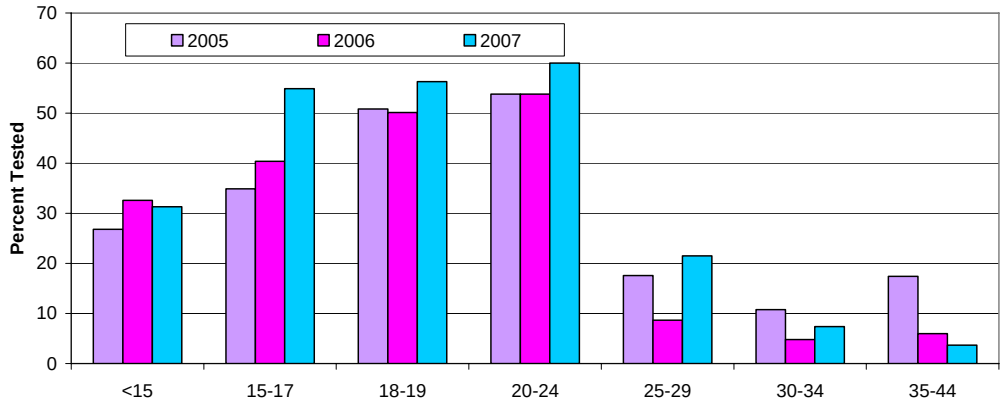
  ☑ The Infertility Prevention Project provides access to no-cost lab testing and treatment medications for gonorrhea and chlamydia for females age 24 and under, males age 29 and under and contacts of infected individuals. Currently no office visit charge is assessed for these individuals. Other tests are available at cost, with no sliding fee scale available.

  ☑ Individuals who are not eligible for the IPP are charged for the cost of testing ($43) and an office visit is charged (ranging in cost from $29 to $134). There is no sliding fee scale.

  ☑ Asymptomatic people can be screened for STI's by the RN; persons with symptoms of STI must be evaluated by the ARNP.

- Current activities
  - ☑ With the exception of chlamydia and chronic hepatitis C, investigation of all reported notifiable conditions is begun within 24 hours of initial reporting.
  - ☑ PHIMS and PHIMS-STD are currently being used by the Department; however, because the systems are slow they are not useful to support real-time investigation. PHIMS participation currently represents double data entry for the Department.
  - ☑ The amount of nurse time allocated for communicable disease has been inadequate to do full investigation and partner counseling and referral for all cases of chlamydia. All other notifiable conditions are investigated completely and case management is applied where appropriate.
  - ☑ Very few chlamydia cases diagnosed by non-public health providers are contacted by public health staff. Current communicable disease procedures do not require that an investigation be done on chlamydia cases that are reported by private providers.
  - ☑ 57% of clients under age 24 seen through the Department's reproductive health clinic in 2007 were screened for chlamydia.

Percent of Unduplicated Clients Tested for Chlamydia by Age Group

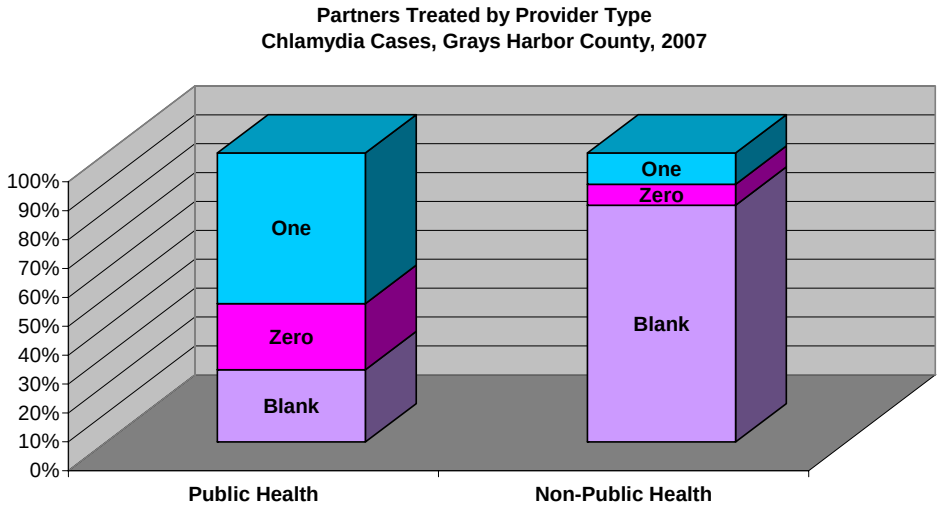


  - ☑ The Department's clinical services include elicitation of partner information and partner treatment for persons diagnosed with an STI. This currently includes about 37% of all reported cases of chlamydia.
    - o In 2007 the "number of partners treated" field was left blank in about 26% of case reports from the Department's reproductive health clinic.
    - o Another 23% indicated that no partners were treated.

- Half of all reports indicated that 1 partner was treated; no reports indicated more than 1 partner treated.

☑ Over 60% of reported chlamydia cases (n=83) were reported by non-public health providers in 2007.

- The "number of partners treated" field was left blank in about 82% of these reports.
- Another 7% indicated no partners were treated
- 11% of reports indicated that 1 partner was treated; no reports indicated more than 1 partner treated.



Barriers to Improvement

- Providers may be reluctant to have public health involved in their desire to protect patient privacy.
- Chlamydia case reports often lag about 2 weeks behind the lab report because the patient is brought back in for treatment before the case report is filed.
- The Department's fees for STI screening are prohibitive for some who are at risk and don't qualify for the IPP.
- SeaMar, the community's Federally Qualified Health Clinic, is not currently taking new patients, which further limits access to health care services for uninsured individuals in the community.
- The Department's procedures for chlamydia do not include provisions for treating pregnant women.
- PHIMS and PHIMS-STI are separate and cumbersome to use.
- The University of Washington has been slow in enrolling local pharmacies in the Expedited Partner Treatment Project (EPT).

Opportunities and Resources

- The Expedited Partner Treatment project provides an interview format and procedures that support effective partner elicitation, notification and referral/treatment.

- Medicaid recently began covering STI screening for asymptomatic Title XIX enrollees.

Analysis

- The recent decline in local chlamydia rates is likely an artifact of decreased screening by public health.

- Eligibility for reproductive health programs is confusing and presents barriers for delivery of appropriate care.

- Routine screening is not being provided to all clients for whom it is recommended under the Infertility Prevention Project.

- The Department is not using all of the potential resources available under the IPP since Medicaid coverage for STI screening services has improved. There is opportunity to screen many more high risk individuals with the little investment of more public health nurse time.

- More public health nurse time will be required to achieve goals related to increased chlamydia detection, investigation, and control.

Goals and Objectives

After their review and analysis of the findings above, the planning group selected the following goals and objectives related to performance measure #2 for 2008.

Goal 2.1. Increase the percent of reported chlamydia cases in which a follow-up interview is attempted

Critical Influence
Health care providers

Objectives

2.1.a. By 5/1/08 update chlamydia procedures to reflect the expectation that each chlamydia case will be offered partner counseling and treatment services. (include an "effective" date).

2.1.b. By 5/1/08 send information from the health officer to all providers who submitted STI case reports in 2007 regarding the changes in Department procedure in investigating chlamydia cases.

2.1.c. By 6/30/08, visit each reporter to deliver and discuss EPT provider letter, new case report forms, and supporting materials. Remove old case report forms during visit.

2.1.d. By 5/1/08 add staff time and adjust duties in this functional area to provide additional public health nurse capacity for the investigation of chlamydia cases.

2.1.e. Beginning 6/1/08, , complete contact interview according to EPT guidelines for the randomly selected 20% of reported cases. Attempt to contact all other patients to complete abbreviated interview as defined in chlamydia surveillance procedures.

Goal 2.2. Increase the percent of reported chlamydia cases in which partner treatment is provided.

Critical Influence	Key Partners
Persons needing TB testing providers	CD treatment

Objectives

2.2.a. By 4/15/08 develop and implement a plan to ensure that clinic capacity exists to see STI contacts for testing and/or treatment within 1 working day of request.

2.2.b. By 6/30/08 update chlamydia treatment procedures to include faxing prescriptions to a pharmacy for contacts who will not or cannot be seen for testing and treatment in the clinic.

Goal 2.3. Increase targeted screening for gonorrhea and chlamydia.

Key Partners
Juvenile detention staff

Objectives

2.3.a. By 5/1/08 update chlamydia screening guidelines to include people outside of IPP age guidelines who report risk factors for disease.

2.3.b. By 4/30/08 complete an analysis of current STI services describing the client base and current fee structure. Present to management to consider impact of changing screening guidelines and/or fee practices.

2.3.c. By 4/30/08 develop an outreach plan for STI screening and present to management for consideration with analysis described above.

2.3.d. By 5/31/08, update chlamydia screening guidelines to include free or low-cost screening for selected high-risk people outside IPP criteria based on management response to analysis of services and fee structure.

2.3.e. Beginning April 1, 2008, routinely screen 100% of persons seen in the public health clinic for an exam or pregnancy test who meet IPP criteria.

Goal 2.4. Partner with DOH to fully implement the Expedited Partner Treatment project

Critical Influence	Key Partners
Local pharmacies	University of WA
Local health care providers	DOH

Objectives

2.4.a. Provide education and/or generate correspondence from the health officer as appropriate to support project implementation.

Goal 2.5. Demonstrate that communicable disease investigations are begun within established timelines.

Objectives

2.5.a. Continue to use PHIMS to report all included conditions to DOH.

2.5.b. Continue to provide feedback to DOH regarding PHIMS performance and function.

Goal 2.6. Document the % of communicable disease reports by providers that are made within established timelines

Objectives

2.6.a. Continue to use PHIMS to report all included conditions to DOH.

2.6.b. Continue to provide feedback to DOH regarding PHIMS performance and function.

Key Performance Indicators

In addition to measuring success at meeting the objectives above, the evaluation of plan implementation will be based on monitoring the following indicators related to communicable disease.

- ☑ The percent of notifiable conditions investigations begun within established timeframes
  Data source: PHIMS
  Baseline:

- ☑ The percent of reports made to the Washington State Department of Health within established timeframes
  Data source: PHIMS
  Baseline:

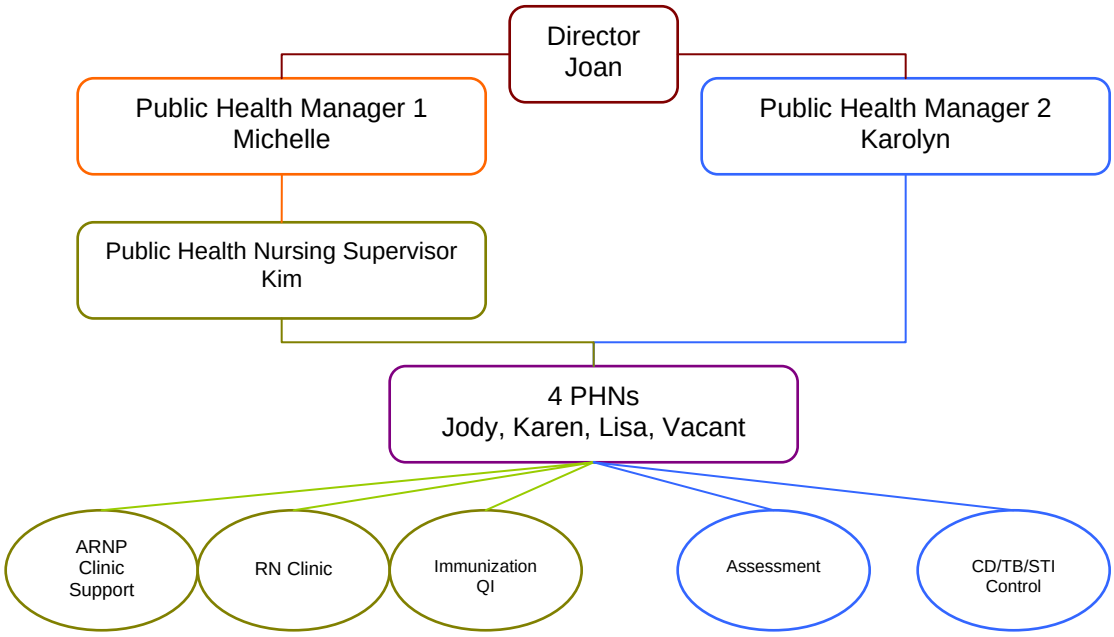
- ☑ The percent of notifiable condition cases reported with a completed investigation.
  Data source: PHIMS
  Baseline:

- ☑ The percent of reported chlamydia cases in which contact investigation is documented.
  Data source: Case reports
  Baseline: 25%

Organizing to Support Improvement

Current Organization: For the past several years, activities to prevent, identify, investigate, and control communicable diseases have been structured as follows:

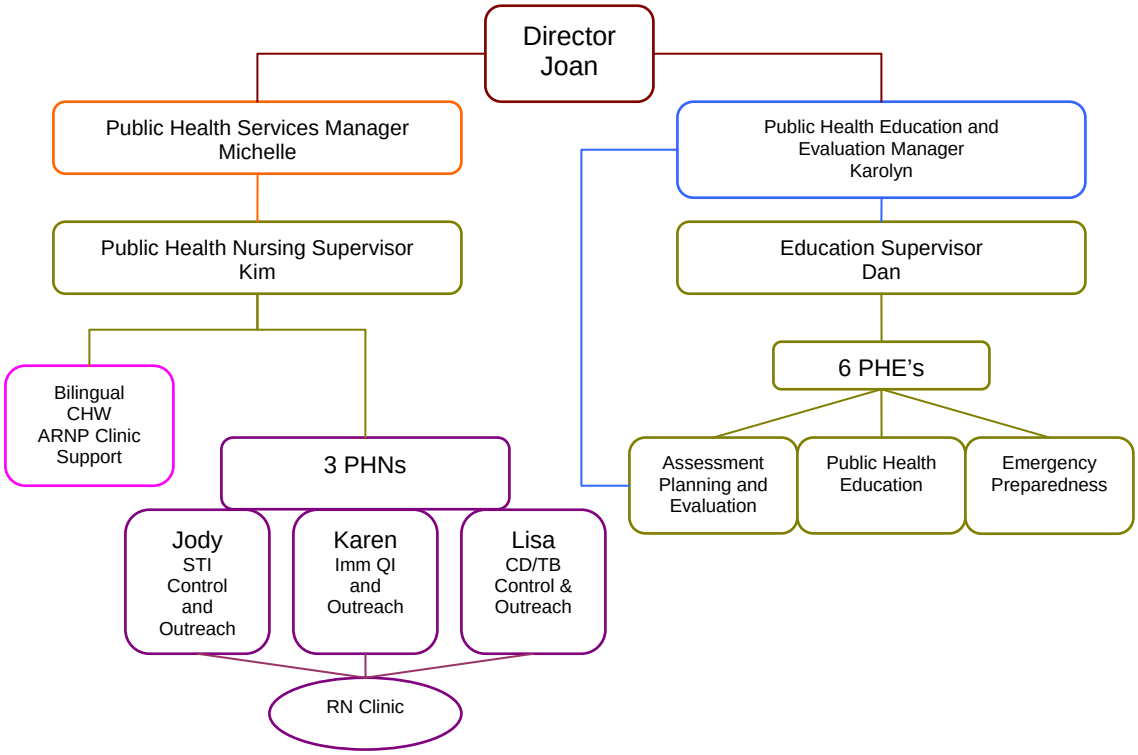
- Forty hours per week of public health nurse time has been assigned to investigation and control of communicable diseases including sexually transmitted infections (STI's), and for case management and clinical care of tuberculosis and perinatal hepatitis B cases and contacts.
- Forty hours per week of public health nurse time has been assigned to support the nurse practitioner's reproductive clinic schedule (32 hours per week). Work has also included contact investigation and treatment for STI's diagnosed among reproductive health clinic patients and managing a recall system for abnormal Pap smears.
- Forty hours per week of public health nurse time has been assigned to administer immunizations, TB skin tests, and provide other "RN services" such as HIV testing, contraceptive method refills, and dispensing emergency contraception (32.5 hours per week). Work also includes providing oversight of and technical assistance for 20 VFC-contracted providers in Grays Harbor County.
- Forty hours per week of public health nurse time has been assigned to support duties as above and provide community health assessment and epidemiology services, including influenza and West Nile virus surveillance. This position has been vacant since November 2007.
- Four full-time public health nurses participated in a rotation through supporting the nurse practitioner in clinic, working the RN clinic, and providing communicable disease services.
- A full-time Public Health Nursing Supervisor has been assigned to supervise the clinical work. Work has also included regular rotation through the public health nurse duties described above.
- Two Public Health Nurse Managers have been involved in management of these functions, with one overseeing clinical functions and the other overseeing activities related to communicable disease investigation and control and community health assessment. The work supervised by these two managers has often overlapped.



Organizational Changes: To support improved communication and enhanced program performance, the following organizational changes have been made:

- Public Health Manager 1 has been designated as the Public Health Services Manager. Public Health Manager 2 has been designated as the Public Health Education and Evaluation Manager.
- Supervision of all Public Health Nurse work described above except community health assessment has been reassigned to the Public Health Nursing Supervisor, who reports to the Public Health Services Manager.
- A Spanish-English bi-lingual Community Health Worker position has been added to support the nurse practitioner's schedule, freeing up PHN time and addressing increasing interpretation needs.
- The three public health nurses will share responsibility to staff the RN clinic. Each will have a lead area (Jody – STI control and outreach; Karen – immunizations; Lisa - communicable disease and TB control) but collaboration and support will occur as appropriate to achieve objectives.
- Department-wide program planning and evaluation responsibility has been assigned to Public Health Education and Evaluation Manager.

- A full-time Public Health Educator has been assigned to community health assessment to support program planning and evaluation efforts. These efforts will be overseen by the Public Health Education and Evaluation Manager.



Performance Management

Performance management and quality improvement of the work in this plan will be conducted by the planning workgroup. Through monthly meetings, the group will

- Monitor progress toward achievement of objectives,
- Monitor performance and key health indicators as data becomes available, and
- Identify and address unforeseen challenges and problems (rapid cycle improvement)

[i] Washington State Department of Health, Behavioral Risk Factor Surveillance System
[ii] Washington State Department of Health, Sexually Transmitted Disease Registry
[iii] Washington State Department of Health, Communicable Disease Report 2006
[iv] Grays Harbor County Public Health and Social Services, Communicable Disease Investigation Data 2008