

5930 Work Plan Template Consolidated Contract Deliverable

LHJ Name: Grant County Health District
Date:
LHJ Work Plan Contact:

Due: February 15, 2010
Send to: tiffany.escott@doh.wa.gov
FAX (360) 586-7424

Performance Measure #1 – Increase the uptake of new and under-used child and adolescent vaccines; specifically focusing improvement efforts and reporting on Varicella, Rota Virus, HPV and pediatric influenza.

Reporting Measure

A: Number of doses of vaccine ordered by each LHJ

B: Number of doses administered as recorded in CHILD Profile

PM#	Objectives / Strategies	Action
1	Increase healthcare provider understanding of immunization schedules and recommendations, to minimize missed opportunities for vaccination.	Face to face visit with each child vaccine provider annually, to offer information, resources and to enhance relationships.
1	Assure reminder-recall activities by child vaccine providers.	Face to face visit with each child vaccine provider annually, to include promotion of CHILD profile resource for reminder-recalls.
1	Development of GCHD policy/procedure in writing and in practice regarding reminder-recall for vaccinations.	Quarterly reminder-recall letters utilizing CHILD profile, to be sent to clients who have been seen in the past 12 months. GCHD staff will attempt contact with any client who has not been seen in the past 12 months, removing them from reminder-recalls in any of the following: the parent says they have a different vaccine provider, all 3 attempts to contact are unsuccessful.
1	Improve vaccination rates within schools.	Provide school-based vaccinations, as mutually agreed upon between school administrative and nursing staff. Promote and provide on-site assistance as mutually agreed upon to enhance use of CHILD profile within schools.

Performance Measure #2 – Improve the timely, complete identification and standard, effective investigation of notifiable conditions per WAC 246-101.

Reporting Measure

A: Percent of notifiable condition cases reported to the LHJ within the required timeframe (per WAC)

B: Percent of notifiable condition cases reported to the LHJ where investigation was initiated within the timeframe specified in the Guidelines

C: Percent of notifiable condition cases reported to the LHJ with a completed investigation as indicated by completion of “essential fields”

PM#	Objectives / Strategies	Action
2	Personal visit annually to each healthcare provider or clinic, and hospital for education regarding notifiable conditions reporting. Include laboratory directors / staff.	Staff will update communicable disease “binder” information to share with providers, maintain electronically to provide e-mail updates.
2	Personal visit by PHN to STD reporting entities to further acquaint them with Expedited Partner Therapy and to enhance their readiness for participation in client interviews and other program aspects for 2011.	0.3 FTE PHN will be dedicated to EPT program. (52 HOURS/MONTH, 12 HOURS/WEEK) NEW: CD nurse will discuss at infection control visits .
2	Internal quality improvement in notifiable conditions reporting.	In response team 4 to 6 times a year, investigation will review most recent PHIMS

		reporting data, such as cases reported, investigated, completed in timeframe, and will refine protocols to address deficiencies. Review of PHIMS data will be a regular part of the Response Team agenda.
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Performance Measure #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.

Reporting Measure

A: Number and description of LHJ activities and interventions to address obesity or chronic disease and association risk factors in the community.

PM#	Activity	Resources
3	Evaluate GCHD internal workplace wellness activities and provide appropriate evaluation information to community.	GCHD Biggest Loser contest, GCHD all-staff meetings wellness component.
3	Survey families to assess barriers in keeping with a nutrition improvement program.	Assessment coordinator in LHJ, healthy communities program participants, Hispanic health group participants.
3	Conduct inventory of school-based resources, programs for obesity prevention, among early adolescents.	Assessment coordinator in LHJ, Healthy Communities projects, Hispanic health group participants.
3	Initiate inventory of community-based resources, programs for obesity prevention, among early adolescents.	Assessment coordinator in LHJ, Healthy Communities projects, Hispanic health group participants.
3	Initiate conversations with school districts regarding assessment of BMI or similar measure.	Pilot programming with small school district, as appropriate.
3	Update current LHJ materials for obesity prevention outreach purposes.	Use information from school or community level assessments of current programs, and review of current literature.