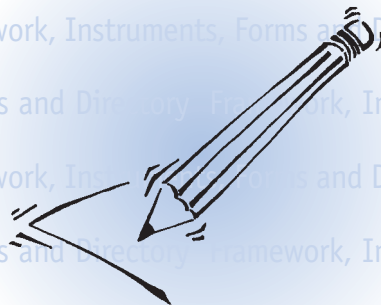# Level III
# Program Performance

*The Community Health Worker Evaluation Tool Kit*

A Project of The University of Arizona
Rural Health Office and
College of Public Health

*"Next We Document Our Work"*
*– CHW*

*Sponsored by*
The Annie E. Casey Foundation

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# Level III
## *Program Performance*

**Tools
Level III**

**Program Performance**

Tools under each level of the framework are listed in alphabetical order by agency. A double asterisk (**) indicates the tool is included in Level III of the Tool Kit. An asterisk (*) indicates the tool is included in a different section within the same level or in an alternate level of the Tool Kit. Please refer to indices of Levels I, II and IV.

### 1.0 Activities/Outputs

**1.1 Aggregate client number receiving services**

| | |
|---|---|
| California Family Contact Form** | *Border Vision Fronteriza* Initiative |
| Juan Diego Community Center Activities Report* | *Centro Comunitario Juan Diego* |
| CHA Semi-Annual Task Activity Checklist | Community Health Advisor Network |

**1.2 Average number of appointments kept**

**1.3 Ratio of appointments made to appointments kept**

**1.4 Number of successful referrals**

| | |
|---|---|
| *Border Vision Fronteriza* Follow-Up Form* | *Border Vision Fronteriza* Initiative |

**1.5 Client service satisfaction**

| | |
|---|---|
| Satisfaction Questionnaire* | The Johns Hopkins University, School of Hygiene and Public Health |
| Client Questionnaire* | Opening Doors, New Mexico |

### 2.0 Outcomes

**2.1 Appropriate or enhanced service use**

| | |
|---|---|
| *Border Vision Fronteriza* Follow-Up Form* | *Border Vision Fronteriza* Initiative |
| Medical Records Review Form** | Opening Doors, Oregon |

**2.2 Cost-benefits per program**

| | |
|---|---|
| Camp Health Aide Program Cost-Effectiveness Analysis | Migrant Health Promotion |
| Nine Core elements and Four Broad Outcomes of Local Community Voices Models* | W.K. Kellogg Foundation, Community Voices Initiative |

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## 3.0 Impacts

### 3.1 Program participant health status

Post-Partum/Newborn Assessment**                Opening Doors, Oregon

### 3.2 Population-based health status

Community Profile**                Community Health Advisor Network

## 4.0 Impacts for organizational development

### 4.1 Policy change within organization or program

Nine Core elements and Four Broad Outcomes                W.K. Kellogg Foundation,
of Local Community Voices Models**                Community Voices Initiative

### 4.2 Access to services

California Family Contact Form*                *Border Vision Fronteriza* Initiative
Checklist for Complete Data Collection Forms                *Border Vision Fronteriza* Initiative
Community Health Survey                East Side Health Worker Partnership
Contact Form and Diary**                *Juntos Contra el Cancer*
Family Contact Form*                Latino Health Access
Glucose, Weight and Blood Pressure Record*                Latino Health Access
Camp Health Aide Program Cost-Effectiveness Analysis                Migrant Health Promotion
Family Health Assessment Form*                Migrant Health Promotion
Group Educational Session Planning and
Evaluation Form                Migrant Health Promotion
Referral and Follow-Up Log*                Migrant Health Promotion
Community Health Worker Practices Log*                Opening Doors, New Mexico
Initial Data Record*                Opening Doors, Oregon

### 4.3 Breadth and depth, quality and quantity of services offered

Assets/Needs Identification Form*                Latino Health Access
Nine Core elements and Four Broad Outcomes                W.K. Kellogg Foundation,
of Local Community Voices Models*                Community Voices Initiative

### 4.4 Institutionalization of the program

Nine Core elements and Four Broad Outcomes                W.K. Kellogg Foundation,
of Local Community Voices Models*                Community Voices Initiative

### 4.5 Access/leverage to additional resources by the program

Nine Core elements and Four Broad Outcome                W.K. Kellogg Foundation,
of Local Community Voices Models*                Community Voices Initiative

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*4.6 Networking and collaboration*

*4.7 Critical reflection and value articulation*

**Tools
Level III**

**Program Performance**

**III.1.1**

University of Arizona Rural Health Office
*Border Vision Fronteriza* Transition Phase 2

**CONFIDENTIAL**

# California Family Contact Form*

Family Last Name: _____

| OFFICE USE: |
|---|

Family Address:_____  Family Zip Code: _____  Phone # where family can be reached: _____

*Promotor/a* Code: _____  Family Code: _____  Previous Contact Dates:___/___ ___/___ ___/___ ___/___

Application:  ❑ New  ❑ Renew   Form Status:  ❑ Refusal  ❑ Complete   Children living at home? ❑Yes ❑No (if No, complete, go to 1-4, and sign)
   ❑ Partially Complete

Initial visit: This was a:  ❑ New Contact   Visit done by: ❑ Telephone ❑ Personal Contact at:  ❑ Family's Home  ❑ BVF Office  ❑ Partner Facility School
   ❑ Follow-up Contact    ❑ Workplace  ❑ School  ❑ Community Event
   ❑ Other:

## A. Family Information: Please check the answer (you do not need to ask each question if you can observe the answer).

1. What language is spoken most frequently at home:  ❑ English  ❑ Spanish  ❑ English and Spanish  ❑ Other: _____
2. Is there a pregnant woman in the family? ❑ Yes ⟶ 3. Is she covered by Medi-Cal?  ❑ Yes  ❑ No
   **If #2 is No, SKIP to # 5.**  ❑ No ⟶ 4. **If #3 is No**, is she applying for Medi-Cal?  ❑ Yes  ❑ No
   **If #3 is No**, is she applying for WIC?  ❑ Yes  ❑ No

## B. Children Information:

5. **For each child who lives at home** (circle all that apply):

| Child Code/ First and Last Name | Date of Birth (mm/dd/yy) | Child has[1] coverage: | | | | | Applying for:[2] | | | | | Appears, not eligible: | | | Child Needs Immunization: | | | In previous 12 months, child has seen and/or had a:[4] | | | Referred to:[6] In the US. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 01 | | P | M | H | W | N | M | H | O | W | N | I | NR | NQI | Y | N | UK | Doctor | Dentist | P.E. | |
| 02 | | P | M | H | W | N | M | H | O | W | N | I | NR | NQI | Y | N | UK | Doctor | Dentist | P.E. | |
| 03 | | P | M | H | W | N | M | H | O | W | N | I | NR | NQI | Y | N | UK | Doctor | Dentist | P.E. | |
| 04 | | P | M | H | W | N | M | H | O | W | N | I | NR | NQI | Y | N | UK | Doctor | Dentist | P.E. | |
| 05 | | P | M | H | W | N | M | H | O | W | N | I | NR | NQI | Y | N | UK | Doctor | Dentist | P.E. | |
| 06 | | P | M | H | W | N | M | H | O | W | N | I | NR | NQI | Y | N | UK | Doctor | Dentist | P.E. | |
| 07 | | P | M | H | W | N | M | H | O | W | N | I | NR | NQI | Y | N | UK | Doctor | Dentist | P.E. | |
| 08 | | P | M | H | W | N | M | H | O | W | N | I | NR | NQI | Y | N | UK | Doctor | Dentist | P.E. | |

1.- Child has:  P=Private Insurance,  M=Medi-Cal,  H=Healthy Families, (CHIP) W=WIC
2.- Child applying for:  M=Medi-Cal,  O=Other,  H=Healthy Families,  W=WIC
3.- Appears not eligible:  I=Income too high,  NR=Out-of-State Resident,
   NQI=Child not qualified immigrant,
   O=Other reasons
4.- Child needs immunization:  Y=Yes,  N=No,  UK=Unknown
5.- Child has seen and/or had a: Doctor,  Dentist,  P.E.=Physical Examination

6.- Refer to: In the U.S.=   **(1)** Private Doctor, **(2)** Outpatient Clinic, **(3)** Community Health Center,
**(4)** Public Health Dept., **(5)** Dentist, **(6)** Medi-Cal/Healthy Families,
**(7)** WIC Program, and **(8)** Other.
In Mexico =   **(9)** Private Doctor, **(10)** Outpatient Clinic, **(11)** Secretaria de Salud -SSA.
**(12)** Seguro Social - IMSS, **(13)** Dentist, and **(14)** Other Mexican Provider

*\* Form is available in Spanish*

**P**rogram **P**erformance

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## C. Assistance Provided by the *Promotor/a:*

6. Did you provide health information to the family? ❏ Yes ❏ No
7. Was the family willing to discuss Medi-Cal/Healthy Families? ❏ Yes ❏ No **If #7 is No, SKIP to Section D Below**
8. Is the family going to apply for Medi-Cal/Healthy Families? ❏ Yes ❏ No (skip to Section D) ❏ Not Sure/don't know
   **If #8 is Yes, SKIP TO SECTION E BELOW:** (DONE FOR NOW -Skip to Section F)

## D. The Family is NOT APPLYING for Medi-Cal/Healthy Families (for any child) OR is Not Willing to Discuss:

9. Please share with us the reasons why your child is not applying for Medi-Cal/Healthy Families (check all that apply):

   ❏ Too much documentation required    ❏ Application process too difficult    ❏ Not enough time to complete application
   ❏ Confidentiality issues    ❏ Don't want government program    ❏ Applied before an denied
   ❏ Child is healthy, don't need program    ❏ No available transportation    ❏ Don't have required documents
   ❏ Immigration concerns    ❏ Can't afford premiums    ❏ Other, pleas explain: _____

## E. Application Assistance:

10. Did you assist in completing the application? ❏ Yes ❏ No
11. Has an application been submitted by this family? ❏ Yes (go to #12)
    ❏ Not yet, but still plan to **(keep this form and continue working with the family)**
    ❏ Changed mind, decided not to **(complete Section D above, sign, and turn in form)**
12. Did you submit the application for he family (e.g. mail for them)? ❏ Yes ❏ No
13. Did the family have an appointment for a Medi-Cal interview? ❏ Yes (go to #14) ❏ No ❏ Not Applicable
14. Did you make their appointment for them? ❏ Yes ❏ No ❏ Not Applicable

## F. Follow-Up:

**OFFICE USE**

15. Number of contacts needed to complete this form (dates): ____/____ ____/____ ____/____ ____/____ ____/____ ____/____ TOTAL: _____
16. Need follow-up to check on Medi-Cal/Healthy Families enrollment status? ❏ Yes ❏ No When ____/____/2000
    Need to follow-up on check on health condition/referral? ❏ Yes ❏ No When ____/____/2000

**Comments:**
_____
_____
_____

*Promotor/a signature:* _____ Form completed ____/____/00
*Form double checked by/date:* _____ ____/____/00

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Opening Doors
Tualatin, OR

II.2.1

# Medical Records Review Form

## I. CLIENT IDENTIFIER INFORMATION

1. Control Group Client: ❏ Yes ❏ No

2. Opening Doors' Client: ❏ Yes ❏ No

3. Client's Name: (skip if control group client)

_____

4. Client's ID number: (skip if Opening Doors' client)

_____

5. Client's Date of Birth: _____

6. Client's Zip Code of Residence: _____

7. Client's Ethnicity:

❏ Caucasian    ❏ Hispanic    ❏ Native American
❏ Asian        ❏ Black       ❏ Other: _____

8. Client's Medical Insurance at Time of Delivery:

❏ Oregon Health Plan:
❏ CAWEM
❏ Private Insurance
❏ Uninsured
❏ Other (please specify)

_____

## II. BABY IDENTIFIER INFORMATION

9. Baby's Birthdate: _____

10. Baby's Gender: ❏ Male ❏ Female

11. Baby's Birthweight: _____

12. Baby's Gestational Age: _____

13. Baby's APGAR scores: First: _____ Second: _____

14. Number of Prenatal Visits: _____

15. Number of Missed Prenatal Visits: _____
(please indicate if unknown)

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16. Number of visits to hospital emergency room and/or urgent care for pregnancy-related issues

_____

(please note if number of visits is unknown):

17. Mother's length of hospital stay (in hours): _____

18. Labor information:          ❏ Spontaneous
                               ❏ Induced

    Type of analgesia used:    ❏ None
                               ❏ IV Medication
                               ❏ IM Medication
                               ❏ Intrathecal (epidural)

19. Did the mother receive any special care due to the delivery?
                               ❏ Yes          ❏ No

    If Yes, please specify:
    _____
    _____
    _____

20. Baby's length of stay in hospital (in hours): _____

21. Did the baby receive any special care due to problems at birth?
                               ❏ Yes          ❏ No

    If Yes, please specify:
    _____
    _____
    _____

22. Total charge for obstetrical care (please indicate if unknown): $ _____

23. Total charge for pediatric care (please indicate if unknown): $ _____

**Name of Data Collector:**
_____

**Name of Data Collection:**
_____

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Tualatin, OR

III.3.1

# Post-Partum/Newborn Assessment

## POST-PARTUM:

Mother's Name _____     Delivery Date _____

Delivering Hospital _____     Admission Date/Time _____

Delivering Dr./CNM _____     Discharge Date/Time _____

Spontaneous Onset:     ❏ Yes  ❏ No
Induced Labor:          ❏ Yes  ❏ No
If Induced, Reason: _____
_____

C-Section:          ❏ Yes  ❏ No     Why? _____
_____

Total Weight Gain: _____

Breastfeeding:          ❏ Yes  ❏ No

Month of First Prenatal Appointment: _____

Birthing Classes:          ❏ Yes  ❏ No     Source: _____

Prenatal Vitamins:          ❏ Yes  ❏ No

Complications During Pregnancy: _____
_____

Complications During Delivery: _____
_____

Emergency Room Visits while Pregnant: _____

Reason: _____

Prior Authorization:          ❏ Yes  ❏ No

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**NEWBORN:**

Name: _____     Sex: _____ DOB _____ Time _____

Birth Weight: _____     Length: _____

Gestation: _____     Discharge Date _____

Breastfeeding          ❏ Yes    ❏ No

Formula               ❏ Yes    ❏ No     Amount: _____ Frequency: _____

Health Status: _____
_____

Health Care Provider _____     Date of 1st. Appt. _____

OHP Status _____     Managed Health Plan _____

Community Health Nurse:    ❏ Yes    ❏ No

Do you have a car seat?     ❏ Yes    ❏ No

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Community Health Advisor Network (CHAN)
The University of Southern Missisipi
A Program of the Center for Sustainable Health Outreach

III.3.2

# COMMUNITY PROFILE

**PUBLIC ASSISTANCE IN  XXXXXXXXXX COMMUNITY /COUNTY**

**PECENT OF RESIDENT'S EARNING DUE TO TRANSFER OF PAYMENTS***

| 1990 | 1991 | 1992 | 1993 | 1994 | 1995 |
|------|------|------|------|------|------|
| % | % | % | % | % | % |

**AID TO FAMILIES WITH DEPENDENT CHILDREN - AFDC**

Percent of Population on AFDC  _____
Number of Recipient Families  _____
Number of Recipient Children  _____
Number of Recipient Adults  _____
Total AFDC Money Payments  _____

**FOOD STAMP PARTICIPATION** [2b]

Percent of Population Receiving Food Stamps  _____
Number of Recipient Households  _____
Number of Recipient Persons  _____
Food Stamp Value  _____

**MEDICAID**[c]

Total Annual Expenditures for Recipients [3]  _____

**SUPPLEMENTAL SECURITY INCOME - SSI ANNUAL PAYMENTS** [d]

| 1990 | 1991 | 1992 | 1993 | 1994 | 1995 |
|------|------|------|------|------|------|

| AGE | Persons Below Number | Poverty % | County Total Number | Percent % |
|-----|----------------------|-----------|---------------------|-----------|
| < 18 years | | | | |
| 5-17 years | | | | |
| 18-64 years | | | | |
| >65 years | | | | |
| Total | | | | |

| AGE | Persons Below Number | Poverty % | County Total Number | % |
|-----|----------------------|-----------|---------------------|---|
| Black | | | | |
| White | | | | |
| Total | | | | |

Sources: Census of the Population and Housing, 1990, Summary Tape File [3A] Bureau of the Census, Department of Commerce.

Notes:      [1] All AFDC statistics are for the month of [2]All Food Stamp Participation data are for the month of
               [3] Medical Expenditures are for year:
Sources:    [a] Labor Market Information Department, MS Employment Security Commission, Month 199
               [b] MS Department of Public Welfare, Annual Report, Fiscal Year 19
               [c] Office of the Governor, Division of Medicaid, year dates
               [d] Regional Economic Information System, Bureau of Economic Analysis, month, 199-

*This tool is part of the CHAN Program Evaluation and Monitoring, a computerized surveillance system*

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| | | |
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## POPULATION POVERTY STATUS DISTRIBUTION: XXXXXXXXXXX COMMUNITY/COUNTY

| Reported Income at Poverty Levels [1] | Persons | |
|---|---|---|
| | **Number** | **Percent** [2] |
| Below Poverty Level [1] | | |
| <125% | | |
| <200% | | |
| >200% | | |
| Total | | |

Notes: 1 Poverty Level is defined as 100% of the Federal Poverty Level [2] Percent Total may not equal 10 due to rounding

Sources: Census of the Population and Housing, 1990, Summary Tape File 3A Bureau of the Census, Department of Commerce.

## FAMILIES IN POVERTY: XXXXXXXXXXX COMMUNITY/COUNTY

| | Families Below Poverty With Children | Total | Total Families in County with Children | Total |
|---|---|---|---|---|
| Female Head of Household | | | | |
| Total | | | | |

▶ _____% (###) of families in X Community are below poverty level.

▶ _____% (###) of families with children  in X Community are below poverty level.

▶ _____% (###) of families with female head of household with children in X Community are below poverty level.

Note: 1 Not husband present
Sources: Census of the Population and Housing, 1990, Summary Tape File 3A Bureau of the Census, Department of Commerce

## MAJOR SOURCES OF PERSONAL INCOME IN: XXXXXXXXXXX COMMUNITY/COUNTY

| | Dollar Amount | Percent of Total |
|---|---|---|
| Transfer Payments | | |
| Manufacturing | | |
| Dividends, Interests, Rent | | |
| Services | | |
| Government | | |

Note: 1 Not husband present
Sources: Census of the Population and Housing, 1990, Summary Tape File 3A Bureau of the Census, Department of Commerce

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## POPULATION DISTRIBUTION BY EDUCATION CHARACTERISTICS IN: XXXXXXXXXXX COMMUNITY/COUNTY

**Persons >3 Years of Age Enrolled in School**

Total: _____

Pre-Primary: _____

Elementary + High School: _____

College: _____

**Persons >25 years of age**

Total: _____

Percent with High School Degree or More: _____

Percent with Bachelor's Degree or More: _____

Note: Table 3 Summary Social, Economic and Housing Characteristics

## HEALTH STATUS DATA IN: XXXXXXXXXXX COMMUNITY/COUNTY

### BIRTHS [1]

Total Births _____

Births <2500 grams _____

Births <37 weeks _____

Births to all Mothers <15 years old _____

Percent of births to unwed Mothers <15 years old _____

Births to Mother 15-19 years old _____

Percent of Births to unwed Mothers 15-19 years old _____

### NUTRITION SURVEILLANCE SYSTEM [2]

▶ For Pregnant Patients (PNSS) _____

Weight Gain: _____

Hematocrit (prepartum) _____

Hematocrit (postpartum) _____

▶ For Pediatric Patients (PEDNSS) _____

Low Weight _____

Obesity _____

Stunting _____

### BEHAVIOR RISK FACTORS [3]

Obesity _____

Hypertension _____

### DISABILITIES [4]

Percent with work disabilities _____

### DEATHS

List top ten causes of deaths

1.- _____ 2.- _____ 3.- _____

4.- _____ 5.- _____ 6.- _____

7.- _____ 8.- _____ 9.- _____

10.- _____

Sources: 1. Vital Records, State Department of Health   2. CDC: Pregnancy and Pediatric Nutrition Surveillance System
3. Behavior Risk Surveillance: State Department of Health
4. Table 7,8: Summary Social, Economic and Houseing Characteristics, 1990 Census

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**COMMUNITY PROVIDER DESCRIPTION IN : XXXXXXXXXX COMMUNITY/COUNTY**

**Data Information Collected:**

| Agency/Organization | Public | Private | Types of Service Provided |
|---|---|---|---|
| | **Check One** | | |
| Health Department | | | |
| | | | |
| | | | |
| | | | |
| Community Health Center | | | |
| | | | |
| | | | |
| Head Start | | | |
| | | | |
| | | | |
| Legal Services | | | |
| | | | |
| | | | |
| Other | | | |
| _____ | | | |
| _____ | | | |
| Other | | | |
| _____ | | | |
| _____ | | | |
| Other | | | |
| _____ | | | |
| _____ | | | |
| Other | | | |
| _____ | | | |
| _____ | | | |

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| Independent Providers | Types of Services Provided |
| --- | --- |
|  |  |
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## SERVICE UTILIZATION IN: XXXXXXXXXXXX COMMUNITY/COUNTY

**Medicaid Program** [1]

| Age Groups | Unduplicated Count of Individuals | |
| --- | --- | --- |
| | **Medicaid Eligible** | **With Billing** |
| <1 year | | |
| <6 years | | |
| <12 years | | |
| <18 years | | |
| 18-24 years | | |
| 25-65 years | | |
| >65 years | | |
| Total | | |

Source:          Medicaid Program eligibility and claims file

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**LOCAL PUBLIC HEALTH SERVICES IN: XXXXXXXXXX COMMUNITY/COUNTY**

**TIME PERIOD COVERED BY DATA REPORT _____ TO _____ .**

| Type of Health Service | Unduplicated Count by Race | | |
|---|---|---|---|
| | Non-White | White | Total |
| **Prenatal Care for Geographic Area** | | | |
| No Prenatal Care | | | |
| Some Prenatal Care | | | |
| Began Care in First Trimester | | | |
| Began Care in Second Trimester | | | |
| Began Care in Third Trimester | | | |
| Total Births in Geographic Area | | | |
| Prenatal Care Provided by Health Department | | | |
| Prenatal Care Provided by Health Center Clinic | | | |
| | | | |
| **Well Child Assessments** | | | |
| Provided by Health Department | | | |
| Provided by Health Center Clinic | | | |
| | | | |
| **Immunizations** | | | |
| Provided by Health Department | | | |
| Provided by Health Center Clinic | | | |
| | | | |
| **WIC Certifications** | | | |
| Provided by Health Department | | | |
| Provided by Health Center Clinic | | | |
| | | | |
| **Chronic Diseases** | | | |
| Provided by Health Department | | | |
| Diabetes | | | |
| Hypertension | | | |
| Pap Smear | | | |
| Provided by Health Center Clinic | | | |
| Diabetes | | | |
| Hypertension | | | |
| Pap Smear | | | |
| | | | |
| **Family Planning Visits** | | | |
| Provided by Health Department | | | |
| Provided by Health Center Clinic | | | |

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W.K. Kellogg Foundation
Community Voices Initiative

III.4.1

# The Nine Core Elements and Four Broad Outcomes
# of Local Community Voices Models

The W.K. Kellogg Foundation's Community Voices Initiative is a five-year project that will have the following broad outcomes:

◆ Sustained increase in access to health services for the vulnerable with a focus on primary care and prevention
◆ Preserve and strengthened safety-net in the community
◆ Changed delivery system in which care is delivered in a much more cost-effective way and quality remains high
◆ Models of best practices that provide examples of different approaches and strategies other communities can select from and adapt to their unique circumstances

To achieve these results, the projects will each have nine core elements. Each project will develop these elements in its own unique way suited to its own community context. The following are the nine core elements:

### 1. A plan and capacity for informing public and marketplace policy

◆ Each project will analyze policy issues related to the accomplishment of project goals
◆ Issues to be explored include:
  ● Ways to expand coverage for those uninsured who are disadvantaged
  ● Ways to create or expand state risk pools
  ● Mechanism for providing incentives and opportunities for more small businesses to cover employees

### 2. A plan and strategy for development and/or refinement of a cost-effective delivery system

◆ Systemic incentives incorporated into the infrastructure of financing factors, conditions, risks, and problems (institutions, professionals) to participate in their own interests
◆ Network of providers
◆ Emphasis on partnerships1
◆ Inclusion of community agencies that deal with the range of factors, conditions, risks, and problems in communities that affect the health of individuals and families
◆ Greater use of more cost-effective providers, such as advanced-practice nurses
◆ Emphasis on primary medical and dental care
◆ Inclusion of culturally appropriate options and alternatives for healing and maintaining health holistically

### 3. Linkages to public health

◆ Comprehensive and coordinated population-based and clinical prevention, involving multiple medical, health, and human services organizations, as well as citizen groups
◆ Inclusion of environmental concerns ( such as the control of roaches in low-income housing due to their association with high rates of asthma in children)

[1] There is no expectation that this system involves vertical or horizontal integration of organizations into a single system that legally controls all the organizations

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**4. Community involvement, which is broadly defined to include the key players of the community**

◆ Ability to bring businesses, unions, elected officials, citizen groups, faith-based organizations, schools, and others to the table
◆ Mechanisms for citizens from diverse sectors of the community to have ongoing voice in setting the direction of the system

**5. Clear plan and capability to hold the provider and community network together through infrastructure that includes:**

◆ Established relationships and enhancement and expansion of relationships
◆ Legal agreements
◆ Management information systems

**6. Explicit responsiveness to the community's context for creating health and wellness**

◆ Methods and measurable objectives for lowering barriers to creating community health that are due to problems in securing healthcare (access problems or lack of coverage)
◆ Methods and measurable objectives for lowering barriers to maintaining and promoting health that are due to community conditions of poverty, unsafe streets, lack of positive activities for youth, etc.
◆ Methods and measurable objectives for responding to cultural differences that relate to health promotion, health risks, self-care, and appropriateness of healthcare
◆ Incorporation of social and economic community development status, needs, and opportunities into the system planning and operations
◆ Recognition of the sociodemographic profile of the community, including citizens' participation in faith-based and social organizations, informal networks, etc.

**7. Effective use of resources to attain systems change**

◆ Serious commitment of local resources to support project as demonstration of "buy-in" from important stakeholders
◆ Project management that uses dedicated staff, time, effort, and resources or other demonstrably effective means to achieve defined targets in projected timeframes

**8. Demonstrated readiness of the organization(s) that will spearhead the community**

◆ Record of innovative problem-solving and commitment to the community
◆ Visionary leadership, such as a creative and competent CEO who can see or anticipate what the future holds and support his/her staff to develop the appropriate set of responses to the changing environment
◆ Commitment and capability for the recruitment and development of new and emerging diverse leaders, including among youth and community members
◆ Commitment to inclusiveness and diversity
◆ Capacity for project evaluation and ongoing evaluation as a management tool to sustain the project
◆ Capacity for informing policy through effective communication and relationships

**9. Capacity to function and serve as a laboratory for systems change in which new approaches can be tested and through which others can learn**

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**Tools
Level III**

Program Performance

*Juntos Contra el Cancer*
University of Arizona

III.4.2

## CONTACT FORM *

PROMOTOR/A NAME: _____ AGE ETHNICITY++

| | | | |
|---|---|---|---|
| **NAME:** | | | |
| Address: | | | |
| Phone #: | | | |
| Zip Code: | | | |
| **CONTACT FORM:** | | | |
| Family, Fiend, Neighbor | | | |
| Direct Target Area Work | | | |
| Indirect Target Area Work | | | |
| Other ◆ | | | |
| **THEMES:** | | | |
| Breast Cancer: | | | |
| Education | | | |
| Breast Self-Exam | | | |
| Mammogram | | | |
| Mammogram Appt. | | | |
| Obstacles to care ◆ | | | |
| **CERVICAL CANCER:** | | | |
| Education | | | |
| Pap Smear | | | |
| Pap Smear Appt. | | | |
| Pap Smear Results | | | |
| Obstacles to care ◆ | | | |
| **CANCER RISK FACTORS:** | | | |
| Diet | | | |
| Exercise | | | |
| Alcohol Use | | | |
| Smoking | | | |
| Drug Use | | | |
| **REFERRAL TO COMMUNITY AGENCY ◆** | | | |
| Medical | | | |
| Educational | | | |
| Religious/Spiritual | | | |
| Social Service | | | |
| Other | | | |
| **OTHER TOPICS:** | | | |
| Getting Acquainted | | | |
| Cancer in Genera | | | |

++ 1 African American    2 Hispanic    3 Native American    4 Asian    5 White

◆ Note in Diary    | 5 | | | | |

*  Form is available in Spanish*

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**NOTES:**

Tools
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Program Performance

5

*Juntos Contra el Cancer*

# CONTACT FORM DIARY*

(Page 1 of 2)

Promotor/a Name: _____    Contact Name: _____

**REFERRED BY:**

Other: _____
_____
_____

**OBSTACLES TO CARE: CODES (Use letter)**

**a.**___care was not available when you needed it
**b.**___cost too much
**c.**___did not have medical insurance
**d.**___did not know where to go
**e.**___medical services are far from where you live
**f.**___have difficulty walking/walking tires you
**g.**___hours were not convenient
**h.**___had to wait too long to get an appt.
**i.**___needed someone to take care of children
**j.**___would lose pay from work
**k.**___had to wait too long in the office/clinic
**l.**___staff at the office/clinic were disrespectful
**m.**___ had no confidence in the clinic

**n.**___ staff/clinic does not speak my language
**o.**___ do not speak English very well
**p.**___ there were no (ethnic group) staff members at the office/clinic
**q.**___ afraid of what the doctor might find
**r.**___ feel embarrassed when the doctor examines you
**s.**___ prefer to put up with the pain instead of going to the doctor
**t.**___ will not give you the time off work
**u.**___ doctor was disrespectful the last visit
**v.**___ lack of communication
**w.**___ difficulty with transportation
**x**___ Other _____

**OBSTACLES TO CARE: Pap Smears**

| Pap Smear Appointments/Where | Missed Appointment (Code/Reason) |
|---|---|
| Appt. 1 | |
| Appt. 2 | |
| Appt. 3 | |
| Appt. 4 | |

**OBSTACLES TO CARE: Mammograms**

| Mammogram Appointments/Where | Missed Appointment (Code/Reason) |
|---|---|
| Appt. 1 | |
| Appt. 2 | |
| Appt. 3 | |
| Appt. 4 | |

| 5 | | | | |
|---|---|---|---|---|

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**CANCER RISK FACTORS:**

**REFERRAL TO COMMUNITY AGENCY:**

**OTHER TOPICS:**

**NOTES:**

| 5 | | | | |

**Tools Level III**

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