Standards for Public Health In Washington State: Baseline Evaluation Report

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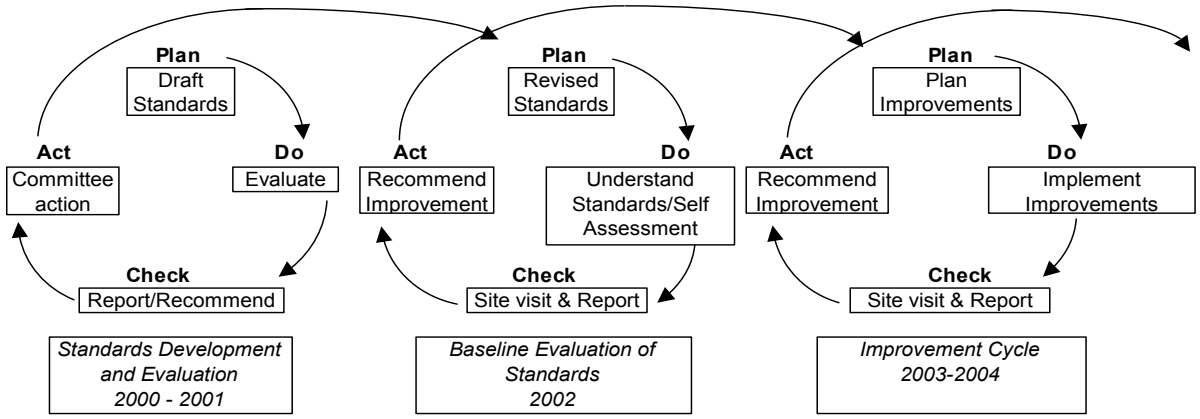
Executive Summary

The Standards

The Standards for Public Health in Washington State were developed through a collaborative effort between state and local health officials. Over the course of several years, more than 150 individuals participated in meetings, workshops and review sessions, resulting in publication of the Standards in 2000, their evaluation through on-site review, and subsequent revision and adoption as of June 2001. This report summarizes the first baseline evaluation of Washington State local health jurisdictions and Department of Health programs against the Revised Standards.

As noted in the 2000 report of the evaluation of the Standards, the process itself uses the Quality Improvement Shewhart cycle: the Revised Standards are the *Plan* step; the self evaluations are the *Do* step; the site visits, data analysis and this report are the *Check* step; and the future work on system improvement will be the *Act* step. The following diagram summarizes the present and future application of the Shewhart cycle to the standards.



The Baseline Evaluation Process

The baseline evaluation included all 34 local health jurisdictions (LHJs) in the state and 38 Department of Health (DOH) program sites selected by the DOH for evaluation. Each site was asked to complete a self-assessment tool regarding the standards and their measures and to prepare for the on-site evaluation by organizing the documentation that demonstrated the standards and measures. An independent consultant reviewed the documentation and scored each measure. This document review and scoring was used for quantitative evaluation. In addition, potential exemplary practice documentation was collected from each site. The on-site

reviews concluded with an exit interview in which qualitative information regarding supports necessary to demonstrate performance and feedback on the Standards was obtained. This "snapshot" of the system was conducted in DOH programs during June 2002 and in LHJs during August and September 2002; improvement to these findings is already underway, based on the learning in preparing for the site reviews and in the exit conferences.

Overall Findings

Current Statewide Performance

In considering overall system performance, it was observed that it is very difficult for any single part of the public health system to fully appreciate the enormous scope of all the activity at DOH and within LHJs. While the Standards are a partnership project between DOH and LHJs, with standards set for the system as a whole and measures separately defined for DOH and LHJs, there is a large body of work performed by DOH that is not seen by and does not directly involve LHJs. This work, however, is also included in the standards review, and many examples were provided of work with other system stakeholders and local entities.

Similarly, most DOH/LHJ joint activity is focused programmatically, leading to limited information on the part of DOH staff about the full scope of work conducted by LHJs. Some LHJs are consolidated Health and Human Services Departments, with major contracting relationships with DSHS and other state and local programs; some LHJs have significant contracting relationships with the Department of Ecology and other entities related to Environmental Health activities. Local LHJ general fund support varies, Environmental Health relies substantially on fee-generated revenues, and there is no substantive state or local earmarked revenue base (minimally addressed by MVET replacement, which is threatened) for many of the functions addressed by the Standards such as Assessment and Communicable Disease. Thus, the examples brought forward by LHJs came from their full scope of work, not just those programs contracted through DOH.

It was also clear that, to the extent that flexible funding exists (e.g., local capacity development funds), there have been differing priorities among LHJs. Some of the very best examples collected, such as intensive assessment activity and community involvement in priority setting, detailed environmental health education materials and classes, or well developed water quality protocols, came into being because of targeted funding, either local capacity development funds or local/regional funding sources.

In light of these points, in considering overall system performance, it cannot be emphasized enough that the scoring was based on the best examples the sites had to offer. In many instances in the LHJs, these examples came from contracted program areas where the planning, evaluation and reporting mechanisms are very specific, and some resources are provided for the quality management of the program as well as the direct delivery of the services. While it demonstrates that sites know how to do the work, it cannot be assumed that they have the staff capacity and resources to replicate their best examples in other areas of activity.

With these caveats, observations regarding overall system performance include:

- The system works as well as it does because of the skills and commitment of the staff and the scope and depth of work being done to improve the health status of the public.

- The strengths of the system are tied to investments that have been made over the last ten years, including: local capacity development funds, which have been used for focused efforts within LHJs; a focus on public involvement and community partnerships; and a focus on developing assessment capacity and products within DOH and LHJs.
- The site reviewers observed that improvements had been implemented and documented in the last two years since the Standards Evaluation process.
- Many state and local processes are person dependent, as they rely extensively on a "rich oral tradition" and the assumption that "everyone knows" what their respective roles are, the right person to contact, or how to complete a task
- Certain areas of performance are strong throughout the system—notably in the topic areas Standards for Public Health Assessment (reflecting a system-wide initiative from the mid 1990s), Standards for Communicable Disease and Other Health Risks, and Standards for Prevention and Community Health Promotion.
- Certain areas of performance are weaker throughout the system—in the topic areas Standards for Environmental Health and Standards for Access to Critical Health Services.
- In the key management practices, the system performs well on Public Information and Community Involvement (again, reflecting system-wide initiatives during the 1990s), with considerable variation in the other six key management practices (Governance Process; Policies, Procedures and Protocols; Program Plans, Goals, Objectives and Evaluation; Key Indicators; Workforce Development; Quality Improvement).
- There is a positive correlation between the size of local jurisdiction budget and/or number of employees and the likelihood of demonstrated performance on roughly a quarter of the measures.
- Having a budget level of $7 million and/or 70 FTEs is predictive of being in the group of LHJs that demonstrated performance on more than 60% of the measures.
- There is also variability among LHJs that is not connected to budget or size. Some small town/rural LHJs demonstrated higher overall performance than some urban LHJs. Of the group of LHJs demonstrating performance on more than 60% of the measures, 27 % were non-urban LHJs with budgets around $2 million and less than 30 FTEs. What may be predictive of their performance is that each of them demonstrated more than 70% of the assessment measures (higher than all but one of their non-urban peers), as well as demonstrating more than 70% performance in one other topic area.
- This variability indicates that performance, while connected to budget and size, also has other drivers. Field observation suggests these may include: local priority setting; leadership; local funding; staff skill, training, and experience; and, documentation and data systems.
- The dilemma for most sites is that the "doing" of the work takes precedence over the documentation of the work; however, the standards and measures focus not only on doing the work but on the quality improvement steps of planning, implementation of changes, and evaluation of the work.

Findings Specific to the Standards and Their Measures

The Standards for Public Health in Washington State are organized into five topic areas. Within each of these five topic areas, four to five standards are identified for the entire governmental public health system. For each standard, specific measures are described for local health jurisdictions and, separately, for the state Department of Health and its programs. It is

important to remember that the topic areas are not synonymous with programs. For example, all of the measures that address public information and media relations are found under the Communicable Disease topic area, but are applicable across the system; similarly, all of the measures related to emergency planning and response are found under the Environmental Health topic area, but are applicable across the system.

Findings are reported separately for LHJs and state programs and summarized in the topic area charts at the end of this executive summary. These charts restate the standards referenced below. Charts that show measure level performance for each Standard are found in Attachment B of the full report.

In the summary analysis that follows, there is a focus on the 50th percentile, in which the midpoint is envisioned as a fulcrum: where the weight falls toward demonstrated performance, fine tuning may be needed, but the system is heading in the right direction; and, where the weight falls towards no or partially demonstrated performance, these areas will require significant planning and assistance to achieve compliance.

Understanding Health Issues: Standards for Public Health Assessment

LHJ Demonstration

- 15 of 24 measures (63%) in this topic area have at least 50% of LHJs demonstrating performance
- For Standards 1, 2 & 3 most all of the measures (80%) had at least 50%or more of LHJs demonstrating performance
- For Standards 4 and 5 most of the measures (60 to 75%) had less than 50% of LHJs demonstrating performance

DOH Demonstration

- 21 of 22 measures (95%) in this topic area have at least 50% of applicable state programs demonstrating performance
- All Standards have more than 70% of programs demonstrating performance across all of these measures

Protecting People from Disease: Standards for Communicable Disease and Other Health Risks

LHJ Demonstration

- 16 of 26 measures (62%) in this topic area have at least 50% of LHJs demonstrating performance
- For Standard 2, 100% of the measures were demonstrated by 50% or more of LHJs
- For Standard 3, one third of the measures were demonstrated by 15% or less of LHJs
- For Standard 5 the average demonstration by LHJs was 39% and two-thirds of the measures for this standard were demonstrated by 50% or less of LHJs

DOH Demonstration

- 20 of 26 measures (77%) in this topic area have at least 50% of applicable state programs demonstrating performance
- In three measures, none of the applicable state programs were able to fully demonstrate performance: 1.5.4, *goals, objectives and measures for communicable disease*, 3.5.3, *annual evaluation of communicable disease investigation*, and 4.5.4, *communication issues during outbreaks are addressed*

Assuring a Safe, Healthy Environment for People: Standards for Assuring a Safe, Healthy Environment for People

LHJ Demonstration

- 9 out of 18 measures (50%) in this topic area have at least 50% of LHJs demonstrating performance
- 9 of the measures were only met by 30% or less of LHJs, sometimes as low as 6%

DOH Demonstration

- 12 of out 20 (60%) measures in this topic area have at least 50% of applicable state programs demonstrating performance
- For Standard 1, only half of the measures had performance demonstrated by 50% or more of the applicable state programs
- For Standard 3, three out of five measures had less than 50% demonstration by applicable state programs
- For two measures, no applicable program fully demonstrated performance: 1.6.5, *education plan identifies performance measures for education programs*, and measure 3.8.3, *development of a quality improvement plan*

Prevention is Best/Promoting Healthy Living: Standards for Prevention and Community Health Promotion

LHJ Demonstration

- 12 out of 19 measures (63%) in this topic area have at least 50% of LHJs demonstrating performance
- For Standard 3, only two of five measures demonstrated performance by 50% or more of LHJs
- For Standard 5, two of four measures had 20% or less of LHJs demonstrating performance

DOH Demonstration

- 16 out of 23 measures (70%) in this topic area have at least 50% of applicable state programs demonstrating performance
- For Standard 4, more than half of the measures had less than 50% demonstration by applicable programs
- Measure 2.7.5, *training in community mobilization methods*, was not demonstrated by any applicable program

Helping People Get the Services They Need: Standards for Access to Critical Health Services

LHJ Demonstration

- 5 of 11 measures (45%) in this topic area have at least 50% of LHJs demonstrating performance
- For Standard 2, no measures had at least 50% of LHJs demonstrating performance
- For Standard 4, both measures had less than 20% of LHJs demonstrating performance

DOH Demonstration

- 8 out of 13 (62%) measures in this topic area have at least 50% of applicable state programs demonstrating performance
- No applicable programs demonstrated measures 1.6.1, *information provided to LHJs about provider availability*, and 2.7.4, *studies regarding workforce needs*

Findings Related to Key Management Practices

Chart 6 at the end of this executive summary provides an overview of performance on measures, organized by key management practices, which cut across all topic areas and standards. The system overall performs very well in the key management practices of Public Information and Community and Stakeholder Involvement, reflecting an effort on the part of the system over the last ten years to improve in these areas. There is considerable variation in the other key management practices.

- LHJs are able to fully demonstrate measures relating to policies and procedures, or planning and evaluation in less than 40% of LHJ sites, while better than 50% of DOH programs are able to fully demonstrate these measures.
- Less than half of LHJ sites can fully demonstrate key indicators to measure and track, while almost 60% of DOH programs are able to do so, largely due to the recent production of The Health of Washington report.
- While LHJs are better able than DOH programs to document staff training efforts, as the recommendations discussion regarding training needs indicates, this often reflects just one person who has been trained.
- LHJs have few examples of quality or process improvement activities—these were fully demonstrated in just 20% of sites, and notably, there was no demonstration in over 50% of LHJ sites. DOH programs were better able to fully demonstrate process improvement activities—these, however, were programmatic and not part of any overall improvement approach within DOH. Review of the detailed charts show that DOH performance on the measures related to quality was strongest in the Assessment area, and variable across the other topic areas.

Other key management practice findings, based on the detailed charts, include:

- Local BOH involvement is least demonstrated in regard to the Access measures, with just 22% of LHJs able to fully demonstrate BOH involvement.
- Measures relating to policies and procedures in the Environmental Health topic area are fully demonstrated in only 16% of LHJs and 30% of DOH programs.
- LHJs can fully demonstrate measures relating to policies and procedures in the Assessment topic area in only 28% of sites, and in the Prevention topic area, 24% of sites.
- Program planning and evaluation measures are fully demonstrated by LHJs in the Communicable Disease topic area by only 19% of sites, and in the Environmental Health topic area, by 23% of sites. Similarly, DOH programs fully demonstrate program planning and evaluation measures for Communicable Disease in only 30% of programs and in Environmental Health, 29% of programs.

Recommendations

The recommended actions fall into three areas: the supports and resources needed to fully demonstrate the standards and measures, clarification and refinement of the Standards themselves, and the future process for integrating the Standards into the system and sustaining the review process.

Supports Needed to Improve Performance

- *Financing and Staff*
  Funding levels are at the top of everyone's list. DOH programs prioritized more and flexible funding as the major support needed, and more staff to accomplish the work envisioned in the standards. LHJ sites also gave top priority to the need for more funding and staff, as well as flexibility in funding. Currently, state or federal programmatic funding drives the ability to deliver most programs at the local level, regardless of established priorities, especially in the smaller jurisdictions. There is little room for flexibility, and there is minimal earmarked state or local funding for some of the basic work of public health as outlined in the Standards, such as Assessment, Communicable Disease and Environmental Health. The site reviews captured the performance of the system as it faces further funding reductions, which challenged even the optimists about how to maintain current performance, much less improve on it.

- *Specific Staff Skills*
  Many DOH and LHJ leaders described the need to find public health staff that can come to the job prepared to do the work. Develop a Human Resources plan that describes professional requirements for an effective health education and promotion staff whether employed by DOH or LHJs, and create recruitment strategies for the system. Similarly, skills in assessment, epidemiology, analysis and program evaluation were mentioned frequently by DOH and LHJ sites; these skills can be especially difficult to find in non-urban jurisdictions and would benefit from a system-wide recruitment approach.

- *Program Planning Processes*
  There is a significant opportunity to reduce administrative demands on LHJs while supporting the development of infrastructure that is consistent for all programs and incorporating the standards into the everyday work of DOH programs and LHJs. Develop model templates (content requirements and format) for project applications, worksheets, program proposals, measurement, program evaluation and reporting that are consistent with and address the Standards and specific measures. To the extent possible (e.g., within the constraints of federal or other funding requirements), adopt the model templates in all DOH programs that contract with LHJs for services.

- *Standard State Databases*
  Standardize databases for clinical services, environmental health, and communicable disease tracking, and use the same data base throughout the local health jurisdictions; standardize systems for data collection, data gathering, and data analysis, including a surveillance system to receive, record, and report on environmental health indicators throughout the state.

- *Standard Key Indicators To Track*
  Over the long term, performance on the Standards should be paired with a consistent set of indicators that provide numeric measurement and benchmarks. There is a strong sense that this work needs to be done statewide, not locally or program by program. DOH should lead a process, along with local assessment coordinators, to develop a simplified approach to standard key indicators (using the Florida model of a brief summary report rather than lengthy narrative descriptions).

- *BOH/Community Involvement*
  One of the strengths of the public health system in Washington is the extent of the community partnerships that have been built at both the state and local levels. This was observed throughout the site visit process. On the other hand, the involvement of local Boards of Health varies considerably; this is especially true relative to the review of data and the linkage between data and health policy. This suggests the development of statewide strategies to strengthen local BOH processes.

- *DOH Consultation and Standard Templates, including Policies and Procedures*
  As with the discussion above regarding key indicators, there is considerable interest in developing model templates that can be adopted throughout the state. While RCWs and WACs provide the legal framework for some programs, there is a need to more clearly spell out in policy or protocol the "what" and "how" and "who" of daily implementation. Consider developing templates for: the basic components of environmental health education; environmental health protocols for investigation and reporting; communicable disease protocols for investigation and reporting: evaluation/self-audit processes for communicable disease and environmental health investigation and outbreak/event management and debriefing; procedures to develop, distribute, evaluate, and update health education and promotion information; and confidentiality policies.

- *Documentation Methods and Information Technology Systems*
  Create the ongoing and institutionalized measurement processes at the state level that are necessary to support LHJs in prioritizing community mobilization regarding critical health services access. Build on the work by the State Board of Health in regard to critical health services (list of services adopted September 2000) and measurement of access to critical health services by creating a report that is a companion to the Health of Washington report (which currently has some components of access tracking)—Indicators of Health Access in Washington.

- *QI/Program Evaluation Skills*
  DOH and LHJ sites indicated that development of skills in the areas of quality/process improvement and program evaluation were needed. In the site reviews, the measures that looked for training or skills in these areas found very few people system-wide. In addition to assuring that training is available, develop and disseminate a model process or template for doing process improvement in a cost efficient manner for use by both LHJs and DOH programs.

- *Role Clarity*
  There continues to be considerable lack of clarity and discomfort with the roles envisioned for both DOH and LHJs in regard to Access to Critical Health Services—even while there is agreement that the healthcare delivery system is in trouble and that access issues for the uninsured have been joined by access issues for Medicaid, Medicare, and in some instances, insured individuals.

  In addition to working on role clarification in Access, develop DOH internal policies regarding roles and responsibilities for programs that address disease outbreaks,

specifically describing the roles among Communicable Disease, Environmental Health and other DOH program areas (e.g., Immunization) and clarify respective roles regarding interaction with LHJs.

- *Training*
  Training should be developed and offered periodically in each of the content areas identified in the key management practice of workforce development, across all topic areas. Specifically, the staff skills and capacity to do quality improvement, program evaluation, community mobilization and health education and promotion have to be developed in addition to skills in providing traditional public health services. Regularly available training should also be available on the core functions of public health—this training was offered during a time of transition, but there are always new people coming into the system who don't have this knowledge base. Both DOH and the LHJs have work to do in consistently training staff regarding confidentiality and data security, as well as on risk communication and emergency response plans.

Revisions to the Standards
There were no significant changes mentioned by site participants in regard to the topic areas or the standards themselves, although "fine tuning" was mentioned for some topic areas, such as Environmental Health. Because this has been a baseline evaluation, it is important to keep the current version of the Standards as stable as possible through the next cycle of site visits. Consequently, topic areas and standards should remain as written. Minor revisions to clarify measures are summarized in Attachment F.

Sustaining the Standards Process
The leadership of the DOH, of LHJs and Boards of Health must embrace and consistently reinforce the message of the standards—*performance and health indicator data form the foundation for establishing health policy and measuring and improving the public health system.*

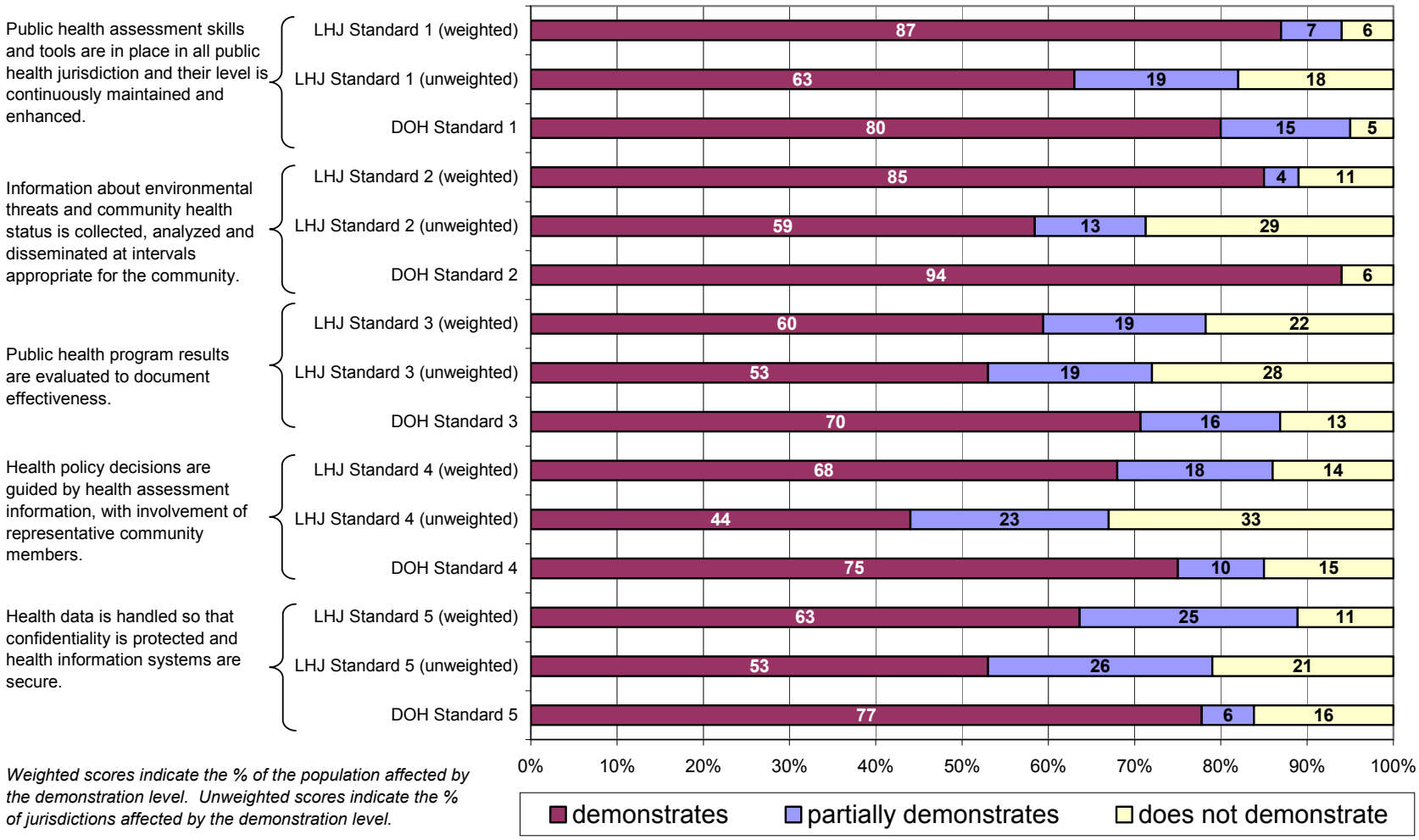
It is necessary that a critical mass of managers and staff are familiar with the standards in order to integrate the philosophy and principles of standards for performance measurement into the culture of the public health system. Orientation to the standards and to the basic principles of performance measurement should be included in the DOH general orientation curriculum and in the specific DOH program and LHJ orientation processes. Assure that another round of training in basic standards and preparing for the site visit is provided in the months before the next cycle of site reviews. Communicate to DOH programs and LHJs that it is essential to send the person(s) who will actually be preparing the materials for the site review—in many instances, the people who actually did the work were not at the trainings and were lacking the information they needed to do the work they were assigned.

The single most consistent piece of feedback about the process is that the timing was terrible, coming as it did during the vacation and budget season. If the site review process were adjusted to occur in the second quarter of the calendar year, the results would be more usefully incorporated into budgets as well as causing less conflict with vacation schedules. The implication of shifting the timing is that the next cycle would occur in either less than two years or at about 2 ¾ years from the just completed site visits. In light of the considerable effort

required of the system to prepare for site visits, the longer cycle is recommended for the next time, to be followed by a more stable two-year cycle.

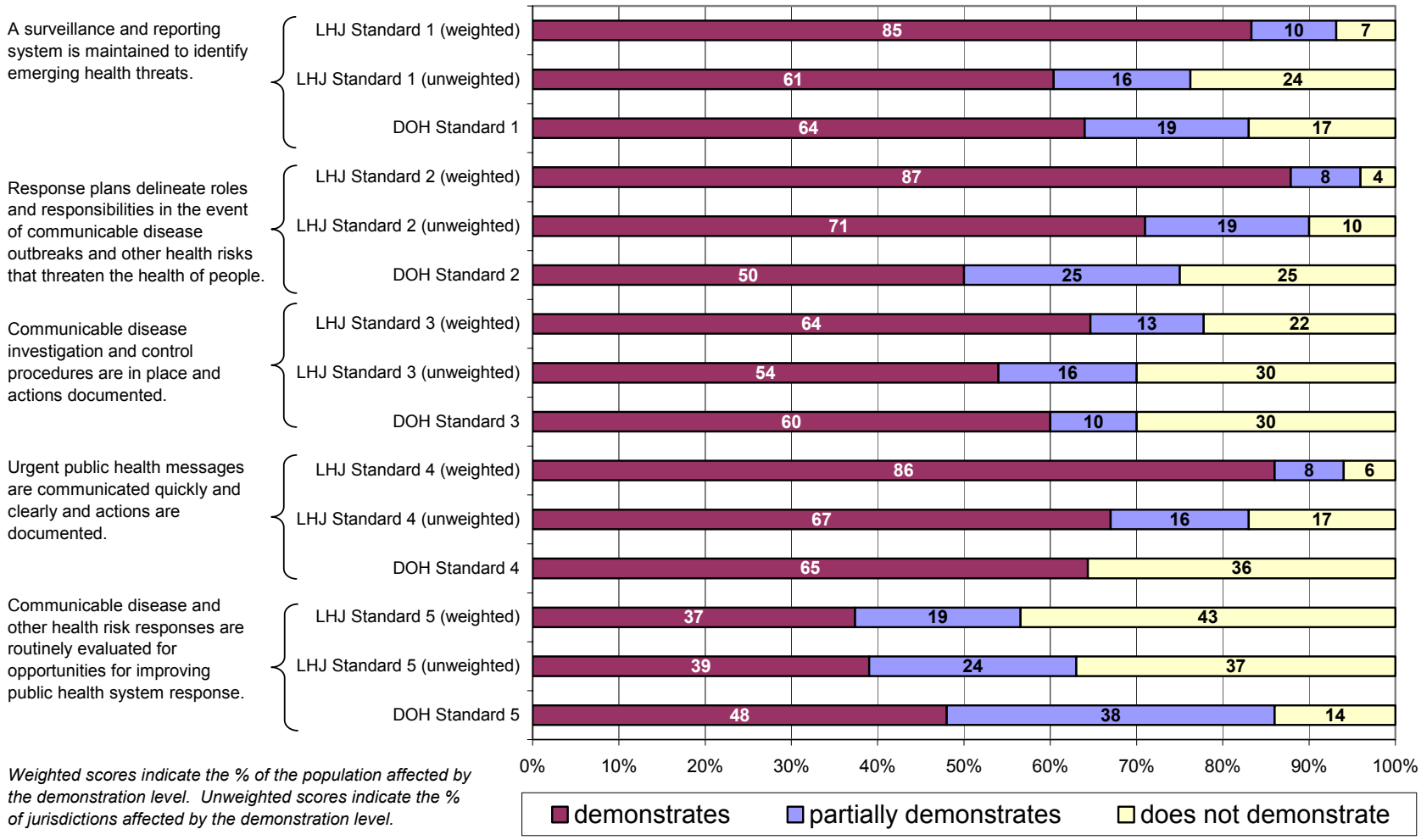
These findings and recommendations should be utilized to determine next steps in the Public Health Improvement Plan (PHIP), leading to the next generation of work on performance management in the Washington State public health system.

Chart 1: Understanding Health Issues - Demonstration Levels of LHJs (weighted and unweighted) and DOH Programs



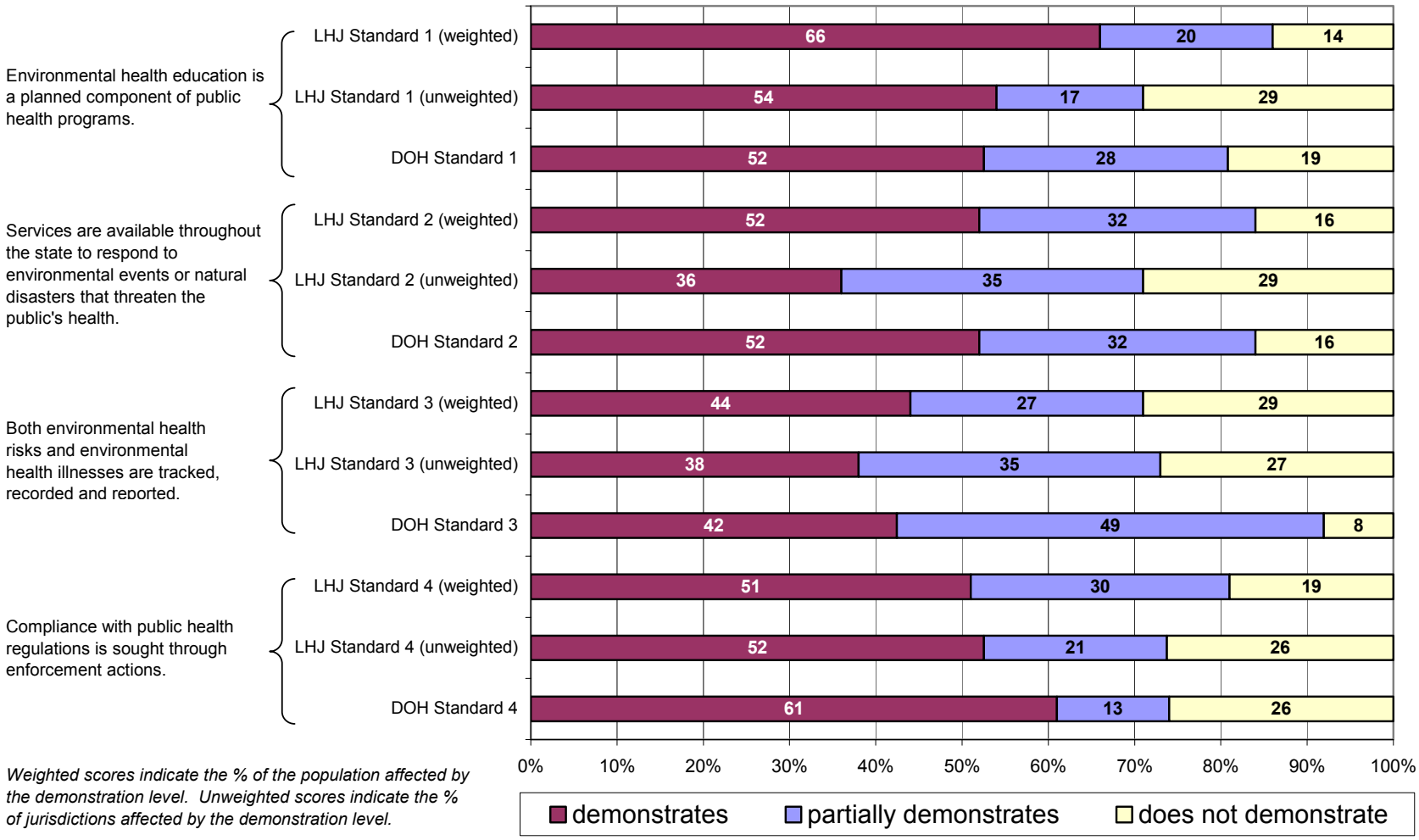
Weighted scores indicate the % of the population affected by the demonstration level. Unweighted scores indicate the % of jurisdictions affected by the demonstration level.

Chart 2: Protecting People from Disease - Demonstration Levels of LHJs (weighted and unweighted) and DOH Programs



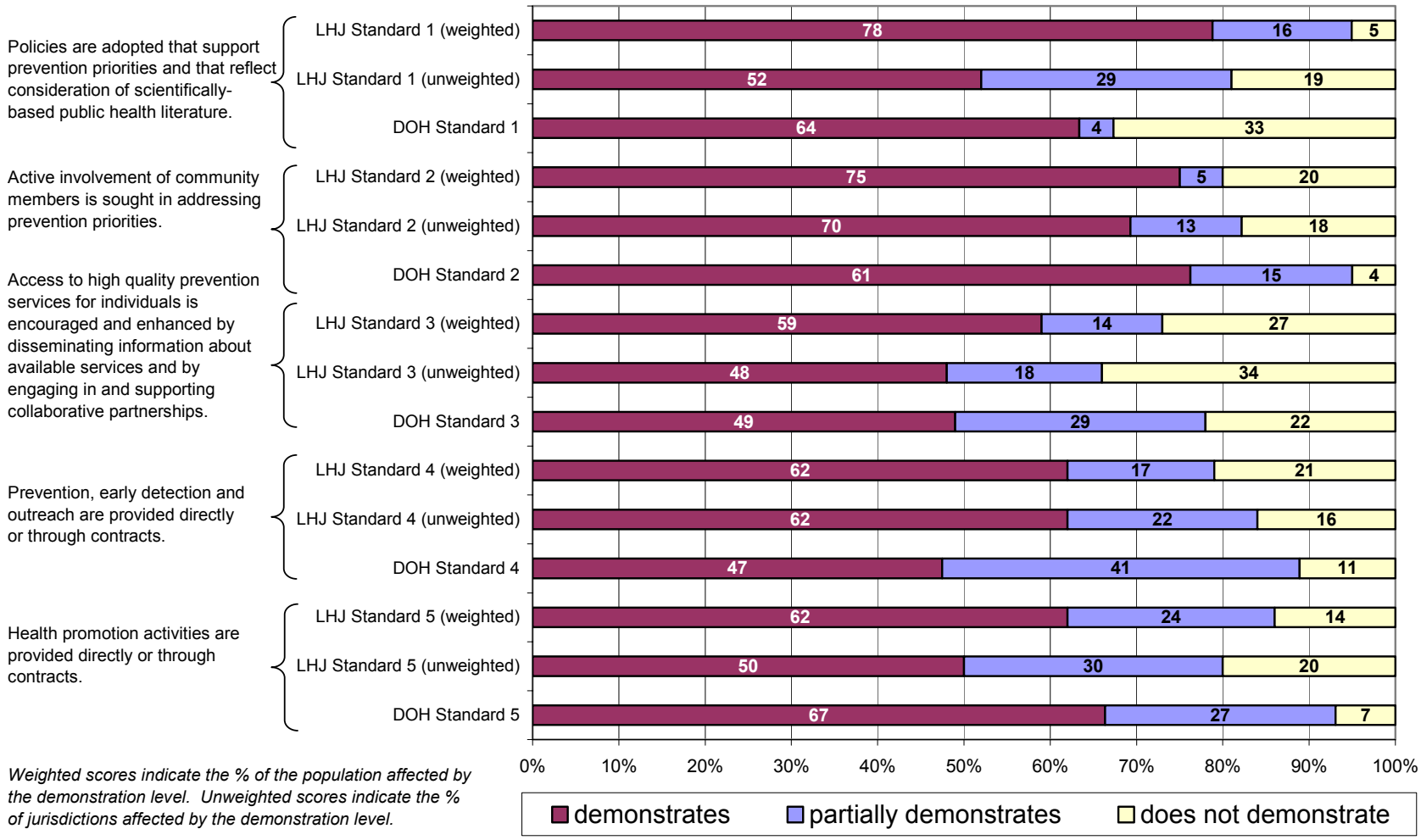
Weighted scores indicate the % of the population affected by the demonstration level. Unweighted scores indicate the % of jurisdictions affected by the demonstration level.

Chart 3: Assuring a Safe, Healthy Environment for People - Demonstration Levels of LHJs (weighted and unweighted) and DOH Programs



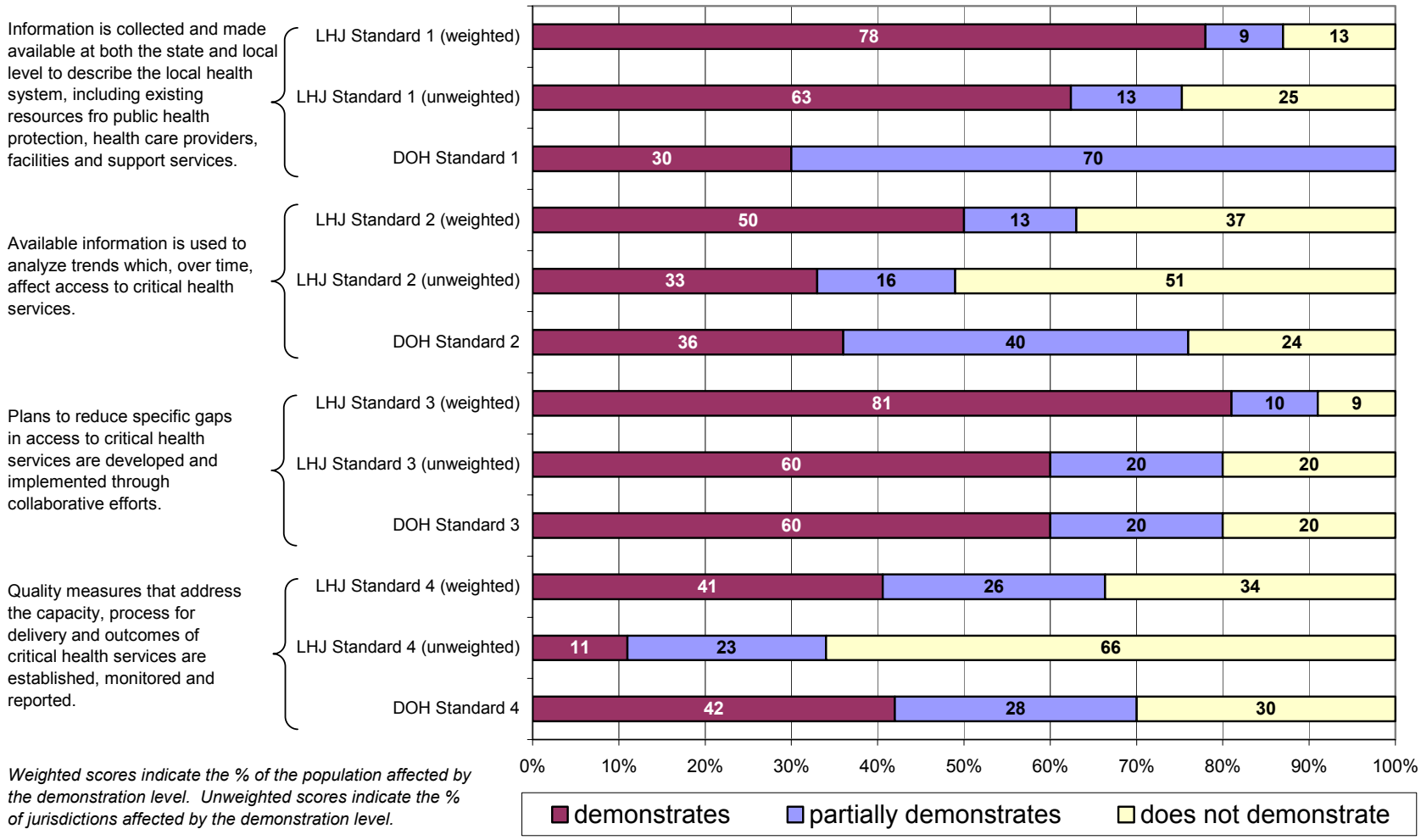
Weighted scores indicate the % of the population affected by the demonstration level. Unweighted scores indicate the % of jurisdictions affected by the demonstration level.

Chart 4: Prevention is the Best: Promoting Healthy Living - Demonstation Levels of LHJs (weighted and unweighted) and DOH Programs



Weighted scores indicate the % of the population affected by the demonstration level. Unweighted scores indicate the % of jurisdictions affected by the demonstration level.

Chart 5: Helping People Get the Services They Need - Demonstration Levels of LHJs (weighted and unweighted) and DOH Programs



Weighted scores indicate the % of the population affected by the demonstration level. Unweighted scores indicate the % of jurisdictions affected by the demonstration level.

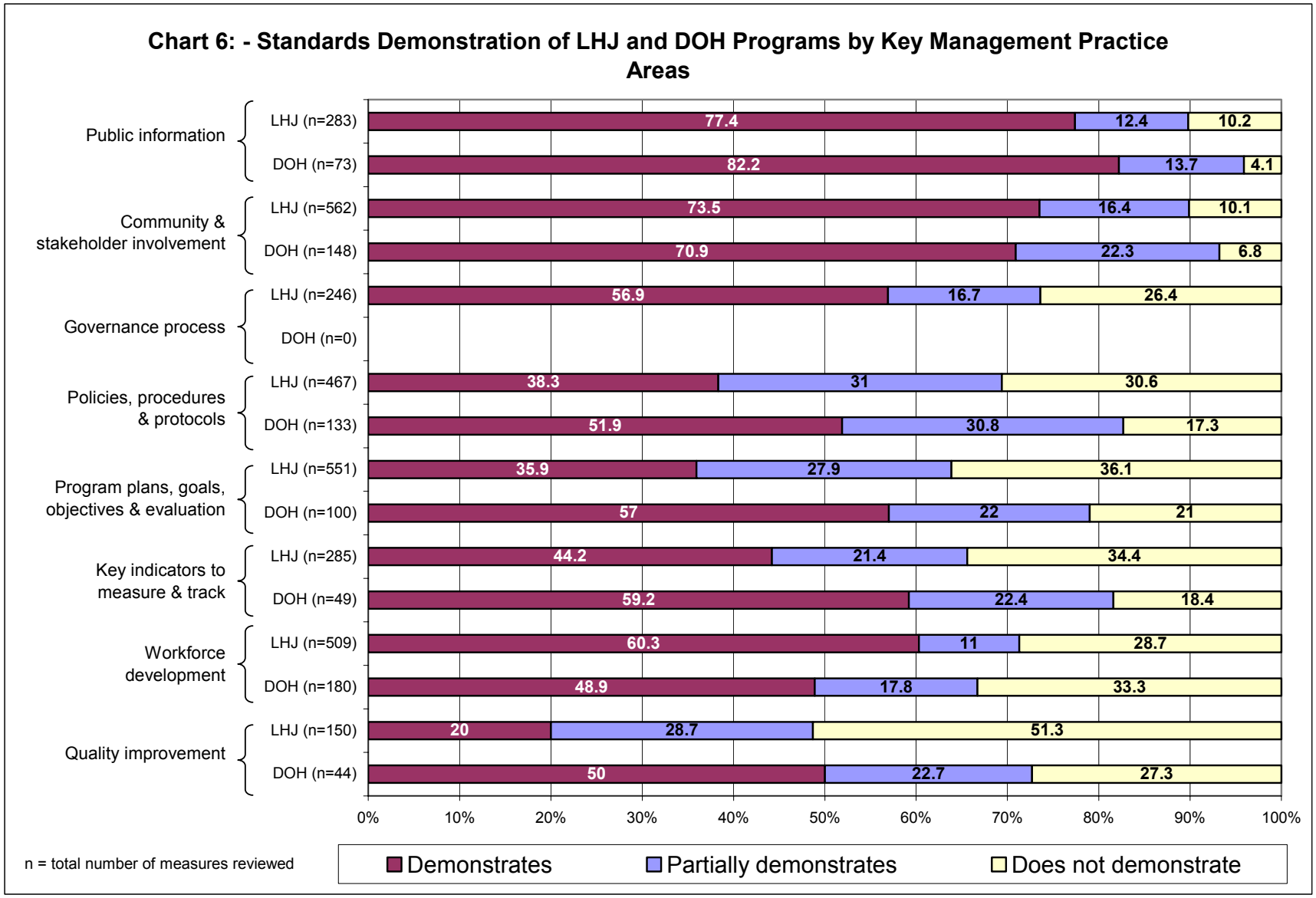


Chart 6: - Standards Demonstration of LHJ and DOH Programs by Key Management Practice Areas
Public information
LHJ (n=283)
77.4
12.4
10.2
DOH (n=73)
82.2
13.7
4.1
Community & stakeholder involvement
LHJ (n=562)
73.5
16.4
10.1
DOH (n=148)
70.9
22.3
6.8
Governance process
LHJ (n=246)
56.9
16.7
26.4
DOH (n=0)
Policies, procedures & protocols
LHJ (n=467)
38.3
31
30.6
DOH (n=133)
51.9
30.8
17.3
Program plans, goals, objectives & evaluation
LHJ (n=551)
35.9
27.9
36.1
DOH (n=100)
57
22
21
Key indicators to measure & track
LHJ (n=285)
44.2
21.4
34.4
DOH (n=49)
59.2
22.4
18.4
Workforce development
LHJ (n=509)
60.3
11
28.7
DOH (n=180)
48.9
17.8
33.3
Quality improvement
LHJ (n=150)
20
28.7
51.3
DOH (n=44)
50
22.7
27.3
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = total number of measures reviewed
Demonstrates
Partially demonstrates
Does not demonstrate

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I. Introduction to the Standards and The Baseline Evaluation Process

A. The Standards and Their Development

The Standards for Public Health in Washington State were developed through a collaborative effort between state and local health officials. Over the course of several years, more than 150 individuals participated in meetings, workshops and review sessions, resulting in publication of the Proposed Standards (May 2000), their evaluation through on-site review, and subsequent revision and adoption as The Standards for Public Health in Washington State in June 2001. This report summarizes the 2002 baseline evaluation on-site review process, findings and recommendations.

The intent of the Standards is to provide an overarching performance measurement framework for the many specific services, programs, legislation and state and local administrative codes that affect public health. The development and evaluation of standards in Washington State has been done in the context of a national conversation regarding performance measurement in public health. A number of states have initiated projects to develop and implement standards. There are similarities and differences in these efforts, adding to the richness of experience and dialogue regarding the public health standards of the future. At the national level, in June of 1999, the National Public Health Performance Standards Program convened a conference that included presentation of "a variety of conceptual, theoretical, and research papers intended to advance the knowledge of public health performance measurement and stimulate dialogue around the program's three goals—quality improvement, accountability, and science." [1] While national consensus about the standards of the future and methods of measurement is a work in progress, there is consensus about these goals. The baseline evaluation using the Standards in Washington State adds valuable information and experience to the methods that will achieve these goals.

The Standards for Public Health in Washington State encompass the core public health functions of Assessment, Policy Development and Assurance, as well as the nationally recognized ten essential services. Attachment A provides a matrix to crosswalk the Standards to both the core functions and essential services. The Standards are organized into five topic areas:

- Understanding Health Issues: Standards for Public Health Assessment
- Protecting People from Disease: Standards for Communicable Disease and Other Health Risks
- Assuring a Safe, Healthy Environment for People: Standards for Assuring a Safe, Healthy Environment for People
- Prevention is Best/Promoting Healthy Living: Standards for Prevention and Community Health Promotion
- Helping People Get the Services They Need: Standards for Access to Critical Health Services

[1] Barry, Michael. Measuring Public Health Performance: A Call to Action. Journal of Public Health Management and Practice. September 2000. Vol. 6, No. 5. Aspen Publishers, Frederick MD.

Within each of these five topic areas, four to five standards are identified for the entire governmental public health system. For each standard, specific measures are described for local health jurisdictions and, separately, for the state Department of Health and its programs. Throughout this report, a reference to the Standards encompasses the entire document at all levels (topics, standards, measures). References to topic areas use the title of the topic area, sometimes in short form (Communicable Disease).

The Standards are also organized into Key Management Practices. These are not reflected in the Standards booklet for the public, but are in a set of topic area matrices distributed to DOH and LHJ managers. The intent of the Key Management Practices is to provide a look across the topic areas at the management themes in the standards:

1. Public information
2. Community and stakeholder involvement
3. Governance process
4. Policies, procedures and protocols
5. Program plans, goals, objectives and evaluation
6. Key indicators to measure and track
7. Workforce development
8. Quality improvement

References to specific standards and/or measures in this report are numbered as in the following example: *CD L 1.3.3* refers to:

- *CD*= the *Communicable Disease* topic area
- *L*= *Local jurisdiction* measure (*S* would designate a *DOH* measure)
- *1*= First Communicable Disease standard (*A surveillance and reporting system is maintained to identify emerging health threats*)
- *3*= Third key management practice *(Governance Process*)
- *3*= Third measure for the standard (*The local BOH receives an annual report, one element of which summarizes communicable disease surveillance activity*).

This example is for a local jurisdiction. The report uses the same numeric protocol for both local jurisdiction and DOH program measures, but clearly separates the findings for local health jurisdictions (LHJs) and state programs (DOH).

B. Standards that "Stretch" the System

The Standards are designed to measure the entire governmental public health system. Because the results of system evaluations are primarily for improving overall performance, the Standards do not describe the system exactly as it is performing at the current time. The Standards articulate a higher level of performance, often described as stretch standards. It is important to understand that the standards and measures are not all immediately attainable by all parts of the system. Stretch standards and measures also provide a more stable measurement tool that yield comparable results over the course of several evaluation cycles.

There are themes embedded throughout the Standards that align with the national goals for standards and can be summarized as follows:

- **Process Improvement**: the Shewhart Cycle (*Plan* → *Do* → *Check* → *Act*) is a key conceptual model in quality or process improvement. This cycle outlines a conscious, documented process for the improvement work of organizations, beginning with a planned approach that is grounded in data, best practice and science; specified sufficiently to be consistently implemented; measured to determine if intended results have been achieved; and regularly reviewed for further improvement opportunities.

  Washington's public health performance standards and measures reflect an improvement cycle. An excellent example is the set of measures for LHJ communicable disease reporting and investigation. Written protocols are required for receiving and managing the communicable disease reports (the *plan* step). Several measures describe the requirements for communicating with providers and with law enforcement as well as training of staff (the *do* step). Then a tracking system with at least annual evaluation of key indicators is required, as well as a debriefing process for major outbreaks (the *check* step). Finally, the implications for investigations, intervention, or educational efforts must be identified and addressed (the *act* step). The improvement cycle is evident in many of the topics that are measured in the Standards.

- **Data Driven Decision Making**: while the assessment topic area focuses specifically on collection and analysis of data, the use of data to establish policy and evaluate the impact of the services provided is referenced many times in the Standards.

- **Best Practices and Consistency of Practice**: the measures in every topic area envision written protocols and procedures that are grounded in science and best practice, as well as regular review of their implementation to identify future process improvements.

- **Documentation of Practice**: associated with the use of written protocols is the expectation that there will be documentation of practice, to be used along with data to support regular review and process improvement.

- **Collaboration and Partnerships**: the context of the community, major stakeholders and the need for their involvement in the work of public health, as well as the community education and mobilization role of the public health system, is reflected in every topic area of the Standards.

These themes are important to keep in mind while reviewing the results of the baseline evaluation and the recommendations for next steps. The report that follows provides the basis for the next phase of this iterative improvement process.

II. Methodology for Evaluation

A. Consulting Team

The PHIP Standards Committee used a Request for Proposal process to select the consulting team. The team members have a wide range of experience in measurement, standards/site reviews, healthcare systems and public sector services (See Attachment E). All members of the team contributed to development of the self-assessment tools, advance materials, and data analysis design; and three participated in site visits at DOH programs; two consultants conducted the local health jurisdictions site reviews. All members of the team participated in the production of this report, which contains both quantitative and qualitative analysis based on the site visits.

B. Training

During the months of May and June 2002, the consultants provided eight full days of training for DOH and LHJ staff and managers to help them prepare for the baseline evaluation of the performance standards. Attendance at the daily sessions ranged from 16 to 36, with 57 DOH attendees and 119 LHJ attendees, for a total of 176 participants.

The training content included presentation slides on the context and the content of the public health standards, and on preparation for the site visits, as well as using a Mock Self-Assessment Tool for five full standards (two DOH, three LHJ). Training participants worked in small groups using the Mock Self Assessment Tool and materials that were collected during the 2000 site reviews. They practiced evaluating these actual materials against the corresponding measures, learning in a "hands-on" session how to understand demonstrated performance on a measure. Evaluations were received from all attendees. The training was well received, with many participants commenting that it had given them helpful information for preparing for the site visits.

C. Site Self-Assessment Tool

The Standards and review process are not intended to serve as an audit; instead, they are a modification of accreditation programs, such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). During a JCAHO survey, the reviewers may review only half or two-thirds of the organization's practitioner sites to evaluate the overall practitioner site performance against the applicable JCAHO standards. When accreditation status is awarded, there is no distinction made regarding the number of program and/or site reviews in one organization compared to another, leading to the accreditation—comparability is assumed.

The Standards provide a picture of what *should* be in place. In this baseline evaluation, each organization identified the sample program materials that would best demonstrate a measure. In future cycles, additional programmatic materials may be requested. It has been generally agreed that no organization in the system can demonstrate the measures in all areas of their work—this is another way in which these are stretch standards.

Each LHJ and DOH program was sent the self-assessment tool six weeks before the targeted submission date. The tool, by giving specific examples for each measure, was intended to assist in the documentation and self-assessment of performance related to the Standards.

The self-assessment tool was designed in table format to facilitate its completion. At the top of the page was the standard and in the first column of the table, each measure was listed. The second column stated the measure in its entirety. The third column contained a description of some of the ways in which the measure could be met. Since each measure might have various ways to demonstrate performance, this list was not comprehensive, but described several possible mechanisms. The LHJ and DOH sites were asked to complete the fourth column by stating the name(s) of the documentation used to demonstrate performance. LHJ and DOH sites were requested to submit their self-assessment to the consultant team before their scheduled site visit, either electronically, by fax, or in hard copy.

These advance materials for sites also described the level of documentation preparation necessary for the site reviews. Any documents cited in the self-assessment were to be available and labeled in terms of the measure or measures to which they applied and organized so that they could be easily located and reviewed. Sites were requested to place all documents in one room so that they could be reviewed systematically.

Separately, each site was asked to identify the supports needed, by topic area, to fully demonstrate the Standards. This information was used in the closing interviews conducted with the LHJ and DOH staff as part of the site visit assessment process.

D. Site Visit, Documentation Review and Data Collection Process

The site visit process included all 34 local health jurisdictions in the state and 38 DOH program sites selected by the DOH for evaluation. For purposes of data collection three of the local health jurisdictions, Whitman, Garfield and Columbia counties, were evaluated together and documented as the Southeast Washington Partnership. This resulted in a total of 32 LHJ data points since the three jurisdictions were evaluated and documented as one LHJ site. In one LHJ (Pacific), the environmental health program, operated as a separate department, elected to not participate in the baseline evaluation. This "snapshot" of the system was conducted in DOH programs during June 2002 and in LHJs during August and September 2002.

Prior to the site visits, consultants reviewed the self-assessment material and noted questions or concerns for follow up. Once the consultants arrived at a site they briefly met with appropriate staff to overview the survey process. They then reviewed the documents that the site had selected to demonstrate their performance regarding the measures. Consultants entered scores and notes on a laptop using a Microsoft Access database form of the *Site Visit Survey* instrument.

The *Site Visit Survey* is a measurement tool that enabled the consultants to record several important pieces of information for each measure:

- The degree to which the site demonstrated performance regarding the measure (rated as *demonstrates; partially demonstrates; does not demonstrate; not able to rate;* and *not applicable*)
- Any comments from the consultants that would help sites to understand the scoring or what might be needed to improve performance regarding the measure
- The documentation that was reviewed to demonstrate the measure
- The documentation that was requested for further review as a potential exemplary practice

E. Scoring

The documentation that was provided by the sites represented their selected examples of how they met the measure. As noted above, the site reviewers did not require examples from all program areas; the examples demonstrated that the site had the understanding and capacity to meet the measure and had done so in at least one program area.

The following guidelines were used for scoring:

- **Demonstrates:** The required documentation was present, with all required elements. For example, LHJ measure EHL 4.6.4 states: *an environmental health tracking system enables documentation of the initial report, investigation, findings, enforcement and subsequent reporting to other agencies as required*. Therefore, in the example above, LHJ documentation must have shown each component of the documentation listed (the initial report, investigation, findings, enforcement and subsequent reporting) to be scored as *Demonstrates*.
- **Partially Demonstrates**: If some documentation was present, but did not include all of the elements, then the measure was scored as *Partially Demonstrates.*
- **Does Not Demonstrate**: If the site provided no documentation, or if the materials presented were not sufficiently related to the measure, then the measure was scored as *Does Not Demonstrate*.
- **Not Able to Rate**: If a site did not submit a completed self-evaluation tool for all or some topic areas, the measures in the topic area not submitted were scored *Not Able to Rate,* as no documentation was provided for the purposes of assessing performance.
- **Not Applicable**: Within DOH, not all measures were applicable to all programs. A matrix developed in advance of the site visits identified for each program the measures for which they should prepare documentation of performance. For that program, all other measures are rated *Not Applicable*. (See Attachment G for a revised version of the DOH matrix). For LHJs, all measures were applicable; however, some (for example those that required certain actions related to an outbreak) were *not applicable* if an event had not occurred.

An important concept used in NCQA and JCAHO accreditation processes is the extent of the review for each measure. The most common type of review is called a "*Sample*". For sample review measures, only some of the components or programs of the organization are evaluated against the measure; as noted above, this was the method principally used for this baseline evaluation. For some measures, accreditation reviewers may be required to evaluate every organizational component selected for the accreditation survey against that measure. This type of review is called "*All*". The final type of review is the measure that can be evaluated once for the entire organization and is called a "*Once*" type of review.

Within DOH, since not all measures were applicable to all programs, modified versions of both "*All*" and "*Once*" were utilized. There were two measures identified that every participating program was to address: AS s 5.7.4 and EH s 2.7.5—these *"All"* measures focused on training (confidentiality and risk communication/emergency response plan).

As a preliminary to "*Once*" measures, when a specific DOH program could not fully demonstrate the established measure without the direct contribution of several other programs it was identified by the site reviewers as a *partnership* measure. Partnership measures were scored once, overall for DOH, rather than at the program level. A measure was not considered to be a partnership measure simply because the program was not able to demonstrate the measure. Examples of criteria used by the reviewers for partnership designation included: multiple programs contributed to a single product; components of the measure clearly required different pieces from different programs; or, there was a reference to a single or standard process or protocol. For this baseline evaluation, nine partnership measures were scored and reported under the Office of the Secretary.

In the future, 27 measures have been suggested by the consultants as DOH "*Once*" measures, where the materials would be presented together once (in one place, not prepared and viewed multiple times in multiple programs) and be scored once. In most instances, the Office of the Secretary is suggested as the location for review of "*Once*" measures. The overarching essence of partnership or "*Once*" measures is their reflection of DOH operating as a system, rather than as individual programs.

Where DOH programs essentially conduct parallel, although similar, activities, these measures can be assigned programmatically. This does not preclude the fact that many of these parallel measures would benefit from standardized approaches. For example, PP s 1.2.2, regarding technical assistance and consultation to assist in local prevention and health promotion planning and evaluation, can be assigned programmatically. However, the request for assistance aspect would be improved by some standardized DOH formats/processes. If a single DOH request process were developed, this would be a "*Once*" measure in the future.

The *Demonstrated Performance on the Measures* section (III) of this report presents results of the scoring. For a more detailed discussion of how the Standards fit into the range of performance measurement approaches nationally, please see Attachment D, which contains a performance management discussion paper prepared for the Standards Committee.

F. Closing Conference

A closing conference took place at the end of each site visit. The purpose of this was to provide the site a snapshot view of the consultant's initial and general impressions of the site's performance, including the documents being requested for the exemplary practice review. Consultants did not provide scoring during the closing conference, pending quantitative analysis. They prepared for the conference by documenting the *Strengths* and *Areas for Improvement* observed during the site review. In addition to focusing on *Strengths* and *Areas for Improvement*, the conference provided an opportunity for sites to discuss any ideas or concerns about the Standards and the site survey process.

From the perspective of the site visit team, the dedication of the staff in the local health jurisdictions and state programs is very impressive; these closing conferences were also an opportunity to acknowledge their commitment and the examples of good work that had been observed.

In the closing conferences, most participants spoke about their support of the Standards conceptually, as well as their frustration at not having in place much of what the measures seek and their desire to work at the level envisioned by the standards. Local jurisdiction staff acknowledged the balancing act of developing standards that can be applied across the range of sizes of LHJs. DOH and LHJ sites also noted that, in times of many priorities and funding reductions, preparation for the site visit required time and effort on the part of staff already stretched thin, especially in smaller jurisdictions where there is minimal support staff and the program managers are also front line staff. Most acknowledged that this baseline evaluation was likely to be the most staff intensive, and many were already talking about how to build their future documentation into maintenance of their site visit files and notebooks.

G. Inter-rater Reliability

In order to ensure that all consultants were rating performance the same way, a test of inter-rater reliability was conducted by having all three consultants independently rate several of the DOH programs. This test resulted in a 58% rating of inter-rater reliability across all three consultants. Of those measures where all three consultants did not agree, 39% of the measures were rated the same by two of the three consultants. All three consultants rated the measures differently in only three percent of the cases. An early work session to review the scoring interpretation and consistency resulted in clarification of several principles that were then consistently employed for the remainder of the assessments. Additionally, the two consultants conducting the LHJ site visits jointly visited the four largest jurisdictions, providing additional opportunity for clarification of interpretation of measures.

H. Data Processing and Analysis

Data processing consisted of importing the scores for all measures for all LHJ and DOH programs from the Access database into an SPSS (Statistical Analysis for the Social Sciences) data file. Quantitative data was cleaned for any miscoding by performing appropriate response range and logic checks.

Data analysis involved the use of appropriate descriptive statistical techniques (in this case frequencies and percentages). A non-parametric test of statistical significance of the relationship between demonstration levels and the following variables was conducted with the Spearman correlation procedure. This technique was used because of its ability to remain robust with small sample sizes.

- Annual budget for each topic area
- Number of employees measured in FTEs for each topic area
- Per capita budget for each topic area
- Per capita FTEs for each topic area

III. Demonstrated Performance on the Measures

A. Overall System Performance

It was clear to the site reviewers that, in the two-year period between the site reviews that tested the Standards and this baseline evaluation, improvements have been developed and implemented in DOH programs and LHJs. Performance was also enhanced for both DOH and LHJs by the clarifications and revisions adopted by the Standards Committee following the 2000 test of the Standards, and for DOH by clarity regarding the applicability of measures to programs.

In considering overall system performance, it was observed that it is very difficult for any single part of the public health system to fully appreciate the enormous scope of all the activity at DOH and within LHJs. While the Standards are a partnership project between DOH and LHJs, with standards set for the system as a whole and measures separately defined for DOH and LHJs, there is a large body of work performed by DOH that is not seen by and does not directly involve LHJs. This work, however, is also included in the standards review, and many examples were provided of work with other system stakeholders and local entities.

Similarly, most DOH/LHJ joint activity is focused programmatically, leading to limited information on the part of DOH staff about the full scope of work conducted by LHJs. Some LHJs are consolidated Health and Human Services Departments, with major contracting relationships with DSHS and other state and local programs; some LHJs have significant contracting relationships with the Department of Ecology and other entities related to Environmental Health activities. Local general fund support for LHJs varies, Environmental Health relies substantially on fee-generated revenues, and there is no substantive state or local earmarked revenue base (minimally addressed by MVET replacement, which is threatened) for many of the functions addressed by the Standards

such as Assessment and Communicable Disease. Thus, the examples brought forward by LHJs came from their full scope of work, not just those programs contracted through DOH.

It was also clear that, to the extent that flexible funding exists (e.g., local capacity development funds), there have been differing priorities among LHJs. Some of the very best examples collected, such as intensive assessment activity and community involvement in priority setting, detailed environmental health education materials and classes, or well developed water quality protocols, came into being because of targeted funding, either local capacity development funds or local/regional funding sources.

In light of these points, it cannot be emphasized enough that the scoring was based on the best examples the sites had to offer. In many instances in the LHJs, these examples came from contracted program areas where the planning, evaluation and reporting mechanisms are very specific, and some resources are provided for the quality management of the program as well as the direct delivery of the services. While it demonstrates that sites know how to do the work, it cannot be assumed that they have the staff capacity and resources to replicate their best examples in other areas of activity.

With these caveats, observations regarding overall system performance include:

- The system works as well as it does because of the skills and commitment of the staff and the scope and depth of work being done to improve the health status of the public.
- The strengths of the system are tied to investments that have been made over the last ten years, including: local capacity development funds, which have been used for focused efforts within LHJs; a focus on public involvement and community partnerships; and a focus on developing assessment capacity and products within DOH and LHJs.
- The site reviewers observed that improvements had been implemented and documented in the last two years since the Standards Evaluation process.
- Many state and local processes are person dependent, as they rely extensively on a "rich oral tradition" and the assumption that "everyone knows" what their respective roles are, the right person to contact, or how to complete a task.
- Certain areas of performance are strong throughout the system—notably in the topic areas Standards for Public Health Assessment (reflecting a system-wide initiative from the mid 1990s), Standards for Communicable Disease and Other Health Risks, and Standards for Prevention and Community Health Promotion.
- Certain areas of performance are weaker throughout the system—in the topic areas Standards for Environmental Health and Standards for Access to Critical Health Services.

- In the key management practices, the system performs well on Public Information and Community Involvement (again, reflecting system-wide initiatives during the 1990s), with considerable variation in the other six key management practices (Governance Process; Policies, Procedures and Protocols; Program Plans, Goals, Objectives and Evaluation; Key Indicators; Workforce Development; Quality Improvement).
- There is a positive correlation between the size of local jurisdiction budget and/or number of employees and the likelihood of demonstrated performance on roughly a quarter of the measures.
- Having a budget level of $7 million and/or 70 FTEs is predictive of being in the group of LHJs that demonstrated performance on more than 60% of the measures.
- There is also variability among LHJs that is not connected to budget or size. Some small town/rural LHJs demonstrated higher overall performance than some urban LHJs. Of the group of LHJs demonstrating performance on more than 60% of the measures, 27 % were non-urban LHJs with budgets around $2 million and less than 30 FTEs. What may be predictive of their performance is that each of them demonstrated more than 70% of the assessment measures (higher than all but one of their non-urban peers), as well as demonstrating more than 70% performance in one other topic area.
- This variability indicates that performance, while connected to budget and size, also has other drivers. Field observation suggests these may include: local priority setting; leadership; local funding; staff skill, training, and experience; and, documentation and data systems.
- The dilemma for most sites is that the "doing" of the work takes precedence over the documentation of the work; however, the standards and measures focus not only on doing the work but on the quality improvement steps of planning, implementation of changes, and evaluation of the work.

In reviewing performance, it is important to remember that the topic areas are not synonymous with programs. For example, all of the measures that address public information and media relations are found under the Communicable Disease topic area, but are applicable across the system; similarly, all of the measures related to emergency planning and response are found under the Environmental Health topic area, but are applicable across the system.

B. Site Specific Performance

Each DOH program site and LHJ site will receive a site-specific report as a foundation for improvement efforts. For LHJs, in addition to seeing the scores for each measure, at the end of each topic area, there is a roll-up of the scores on all *applicable, rated* measures in the topic area (the percent of measures scored as *demonstrates*, the percent scored as *partially demonstrates*, the percent scored as *does not demonstrate*). Next to the roll-up for the topic area is a roll-up for peer counties, and then a statewide LHJ roll-up.

Table I: Peer Groups for Baseline Evaluation Analysis

Small Town/Rural	Mixed Rural	Large Town	Urban
Adams	Clallam	Asotin	Benton/Franklin
Columbia	Grays Harbor	Chelan/Douglas	Cowlitz
Garfield	Island	Grant	King
Jefferson	Mason	Kittitas	Kitsap
Klickitat	Skagit	Lewis	Pierce
Lincoln		Walla Walla	Snohomish
NE Tri-County		Whitman	Spokane
Okanogan			SWWHD*
Pacific			Thurston
San Juan			Whatcom
Wahkiakum			Yakima

* At the time of the site review, included Skamania, which is classified as mixed rural

The peer groupings are based on the DOH *Guidelines For Using Rural-Urban Classification Systems for Public Health Assessment* (for detail on the methodology, please see Attachment C, which also provides a summary of percent of measures demonstrated, by peer group by topic area). The method used provides a more textured way of analyzing differences than a simple urban/non-urban split. However, the methodology may not be familiar to all counties and the groupings are not necessarily intuitive. As noted in the DOH Guidelines, there are a number of methods for rural-urban classification, each having strengths and drawbacks—the intent here was to use an established method rather than creating yet another approach for organizing and displaying the data (which, in any event, does not affect the data itself). This grouping methodology did not preclude analysis of other factors that may influence performance (see discussion on Relationship of Performance to Peer Group, Annual Budgets, and Number of Employees).

Also, there is no intent, in this improvement-focused effort, to compare specific LHJs to one another. However, this roll-up data does provide each LHJ site reviewed with performance benchmarks. If a local jurisdiction is not comfortable with the peer grouping used, Attachment C provides alternative peer group benchmarks.

DOH program reports also provide scoring for each applicable measure, but do not include a summary at the end of each topic area, as there were insufficient applicable measures in most programs to report scores at the topic area level. In a separate report for each Division, for each topic area there is a roll-up of the scores on all *applicable, rated* measures in the topic area (the percent of measures scored as *demonstrates*, the percent scored as *partially demonstrates*, the percent scored as *does not demonstrate*). Next to the roll-up for the topic area is a roll-up for DOH. Again, this roll-up data provides performance benchmarks.

Both DOH program and LHJ site reports provide an overall rollup for all topic areas. DOH Divisions and LHJ sites will also see the percent of measures scored as

demonstrates, the percent scored as *partially demonstrates*, the percent scored as *does not demonstrate* for the Key Management Practices.

C. Local Health Jurisdictions: Overall Performance

In the following analysis, information is provided for each topic area of the standards, followed by an analysis of overall performance on LHJ measures. The charts in Attachment B provide detail on the percent of LHJs able to demonstrate performance on each measure in a topic area. At the end of this overview of LHJ performance, Chart 7 summarizes all LHJs, by topic area; Charts 8 through 12 summarize LHJ performance by peer grouping, by topic area.

In this summary analysis, there is a focus on the 50th percentile, in which the midpoint is envisioned as a fulcrum: where the weight falls toward demonstrated performance, fine tuning may be needed, but the system is heading in the right direction; and, where the weight falls towards no or partially demonstrated performance, these areas will require significant planning and assistance to achieve compliance.

Only two measures had 95% or better of LHJs able to fully demonstrate performance– CD L 3.2.1 and AC L 1.4.2 – both regarding *lists of community provider resources*. On the other end, no measure had fewer than 5% of LHJs fully demonstrating performance; CD L 3.5.4, *evaluation of CD investigations*, was fully demonstrated by only 6% of LHJs, as was AC L 4.7.2, *training in quality improvement methods*. There were no measures where no LHJ was able to demonstrate performance.

1. Standards for Public Health Assessment

For almost two-thirds of the measures in this topic area (15 of 24 measures), at least 50% or more of the LHJs demonstrate performance. The exceptions (1.4.2, 2.4.3, 3.8.5, 4.3.2, 4.4.3, 4.5.4, 5.4.2, 5.4.3, and 5.7.4) indicate areas of needed improvement around the issues of:

- Developing written procedures and policies for obtaining technical assistance on assessment issues and for describing how population level investigations are carried out for emerging health issues
- Quality improvement of activities that is based on analysis of key indicator or performance measure data
- Creating BOH reports and written protocols that summarize assessment data and provide recommended actions for guiding health policy decisions
- Ensuring that key indicator data and related recommendations are used in evaluating program goals and objectives
- Ensuring documentation of confidentiality procedures such as: assuring written policies regarding confidentiality and data security; demonstrating that all program data is submitted in a confidential manner; and documenting that employees are trained regarding confidentiality

To further emphasize the points made above, it should be noted that, for Standard 1 (*Public health assessment skills and tools are in place in all public health jurisdictions and their level is continuously maintained and enhanced*), Standard 2 (*Information about*

environmental threats and community health status is collected, analyzed and disseminated at intervals appropriate for the community) and Standard 3 (*Public health programs results are evaluated to document effectiveness*), most of the measures (80%) were at 50% or more in demonstrating performance. Conversely, in Standard 4 (*Health policy decisions are guided by health assessment information, with involvement of representative community members*) and Standard 5 (*Health data is handled so that confidentiality is protected and health information systems are secure*) for most of the measures (60% to 75%), LHJs demonstrated performance below 50%.

2. Standards for Communicable Disease and Other Health Risks

For almost two-thirds of the measures in this topic area (16 of 26 measures), at least 50% or more of the LHJs demonstrate performance. The exceptions (1.2.2, 1.5.5, 3.4.3, 3.5.4, 3.6.5, 4.4.3, 5.2.1, 5.4.3, 5.5.4, and 5.8.6) indicate areas of needed improvement around the issues of:

- Disease reporting and disease key indicators for investigation
- Developing disease protocols for investigation, conducting annual evaluations of disease investigations, and identifying key performance measures for disease investigation
- Developing roles for working with the news media
- Evaluation of outbreak response including reviewing documents, revising local protocols, identifying issues to be addressed in future goals, and providing a debriefing process of the response to disease outbreaks

It should be noted in regard to the comments above that all of the measures for Standard 2 (*Response plans delineate roles and responsibilities in the event of communicable disease outbreaks and other health risks that threaten the health of people*) were demonstrated at 50% or more of the LHJs. However, for Standard 3 (*Communicable disease investigation and control procedures are in place and actions documented*), two of the 6 measures were demonstrated by 15% or less. For Standard 5 (*Communicable disease and other health risk responses are routinely evaluated for opportunities for improving public health system response*) the average demonstration level was 39%. Two-thirds of the measures for this particular standard were demonstrated by 50% or less.

3. Standards for Assuring a Safe, Healthy Environment for People

At least 50% or more of the LHJs were found to demonstrate performance for only half of the measures in this topic area (9 of 18 measures). The exceptions (1.5.3, 1.6.4, 2.4.3, 2.5.4, 2.7.5, 3.6.2, 3.8.3, 4.4.2, and 4.5.3) indicate areas of needed improvement around the issues of:

- Developing plans for environmental health education that provides goals, objectives for learning outcomes, and in identifying performance measures for educational programs
- Developing procedures for evaluating emergency response plans, for defining staff roles in an emergency situation, and ensuring staff are properly trained in these procedures

- Ensuring a surveillance system is in place to report key indicators for environmental health risks, and having a quality improvement plan that includes consideration of environmental health information
- Developing compliance procedures for all areas of activity and providing a documented process for review of enforcement actions

Especially noteworthy is the fact that all measures mentioned above as areas needing improvement were only demonstrated at 30% or less, sometimes as low as 6%.

4. Standards for Prevention and Community Health Promotion

For almost two-thirds of the measures in this topic area (12 of 19 measures), at least 50% or more of the LHJs demonstrate performance. The exceptions (1.5.3, 3.6.2, 3.5.3, 3.8.5, 4.4.2, 5.4.2, and 5.5.3) indicate areas of needed improvement around the issues of:

- Developing prevention services that are reflected in the goals and objectives of the LHJ's annual plan
- Developing and implementing evaluation of prevention services, gap analysis, use of results for program improvement, and a quality improvement plan for incorporating findings
- Ensuring that outreach and health education materials meet the needs of diverse audiences
- Developing procedures for organizing, distributing, and evaluating health-promotion materials
- Developing goals, objectives, and performance measures for health promotion efforts

To further emphasize the needed improvement in regard to developing evaluation of prevention services, it is noteworthy that only two of the five measures under Standard 3 (*Access to high quality prevention services for individuals, families, and communities is encouraged and enhanced by disseminating information about available services and by engaging in and supporting collaborative partnerships*) demonstrated performance by 50% or more of the LHJs. Regarding the development of procedures and performance measures for health promotion materials, two of the four measures under Standard 5 (*Health promotion activities are provided directly or through contracts*) demonstrated performance by 20% or less of the LHJs.

5. Standards for Access to Critical Health Services

Less than half of the measures in this topic area (5 of 11 measures) were demonstrated by 50% or more of the LHJs. The exceptions (1.5.3, 2.6.1, 2.5.2, 2.3.3, 4.8.1 and 4.7.2) indicate areas of needed improvement around issues of:

- Assessing and reporting availability of critical health services
- Identification of key measures and gaps in access to critical health services in reporting
- Providing an annual report to the BOH regarding access to these services
- Developing a quality plan for directly offered clinical services with performance or outcome based measures
- Training of staff in quality improvement methods

The focus on measuring and reporting gaps in access to critical health services is underlined by the fact the LHJs did not demonstrate performance at 50% or more for these measures (Standard 2: *Available information is used to analyze trends, which over time, affect access to critical health services*). There should also be a stronger focus on developing quality plans with performance measures and in training of staff in these methods. Not only did the LHJs not demonstrate performance at 50% or more for these measures (Standard 4: *Quality measures that address the capacity, process for delivery and outcomes of critical health services are established, monitored, and reported*), but the performance on these measures is the lowest of all the measures across all the standards.

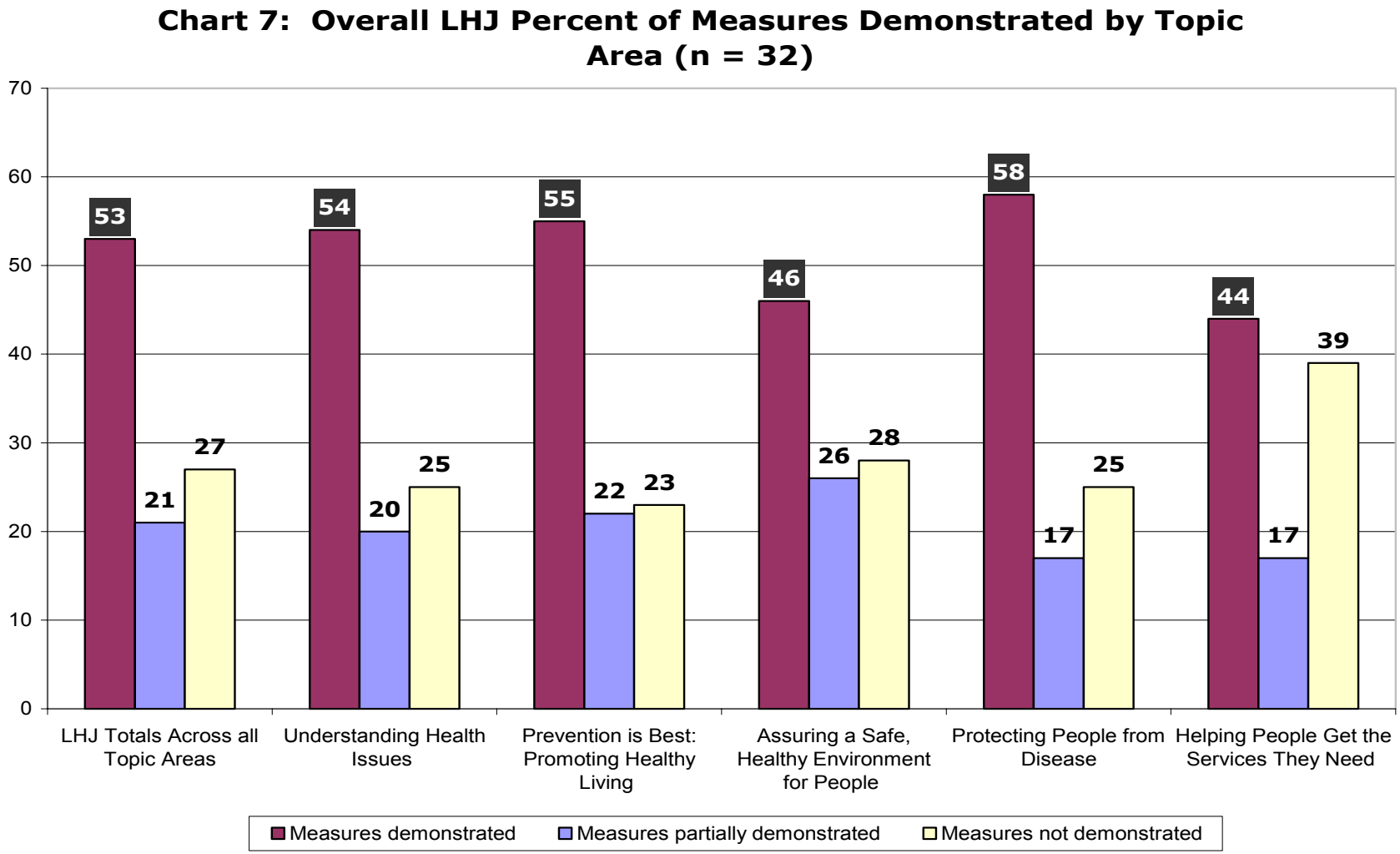
6. Summary of Performance Demonstrated: Local Health Jurisdictions

In the aggregate across all LHJs, measures and topic areas, LHJs could demonstrate performance on 53% of the measures. This is the "roll up" average of the percent of measures where LHJs were able to fully demonstrate performance. This aggregate level falls below 50% in the Environmental Health and Access topic areas. This percent of measures demonstrated varied widely among LHJs: the highest was 81%, the lowest was 25%. LHJs falling into the *urban* peer group had the highest percent of measures demonstrated (average 65%) across all topics. The other peer groups (*mixed rural, small town/rural and large town*) averaged 43 to 45% percent of measures demonstrated across all topics.

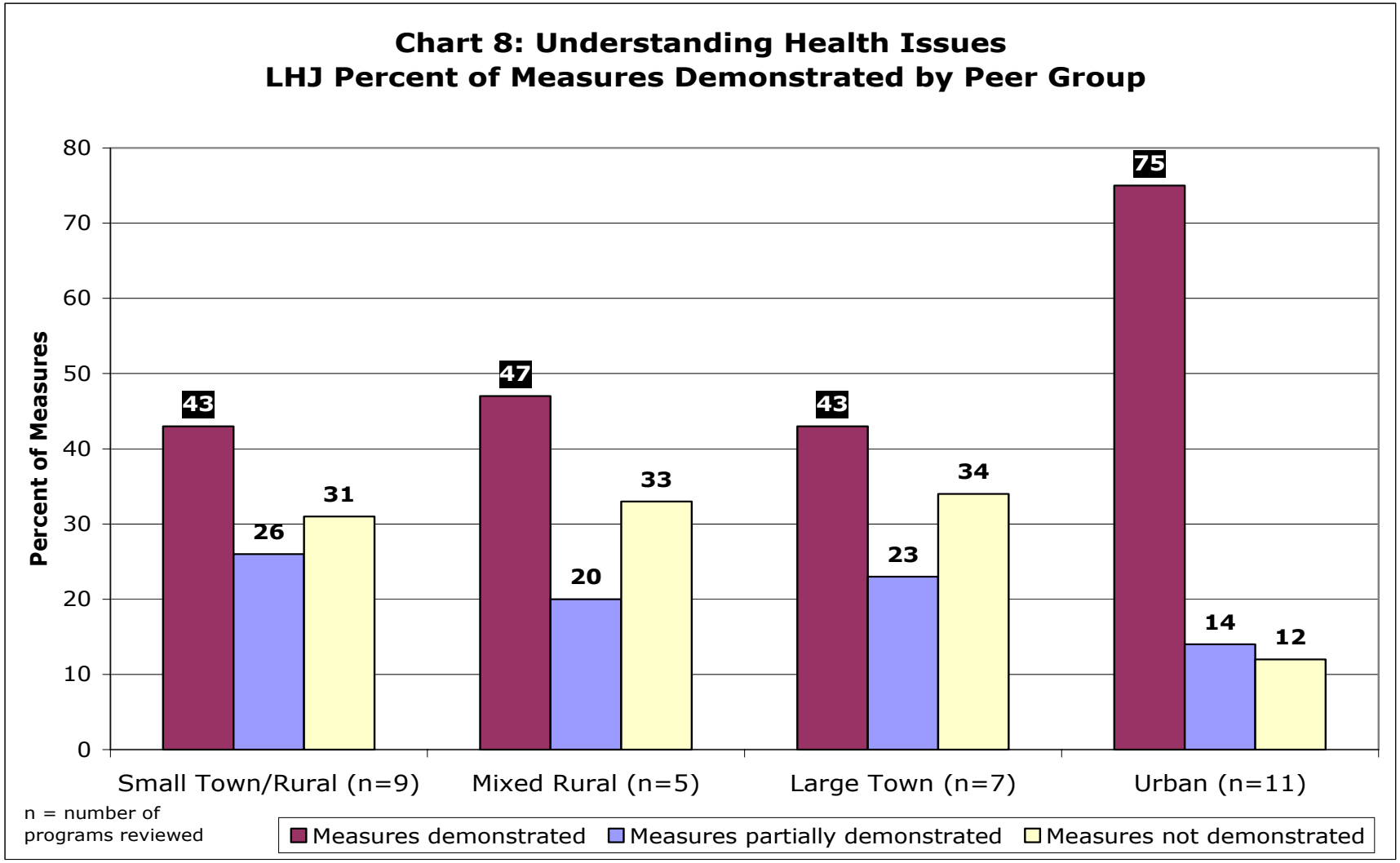
However, there was also considerable variation within each of the peer groups.

- *Small Town/Rural*: Overall percent of measures demonstrated was as high as 65% to as low as 35%
- *Mixed Rural*: Overall percent of measures demonstrated was as high as 52% to as low as 26%
- *Large Town*: Overall percent of measures demonstrated was as high as 65% to as low as 25%
- *Urban*: Overall percent of measures demonstrated was as high as 81% to as low as 54%

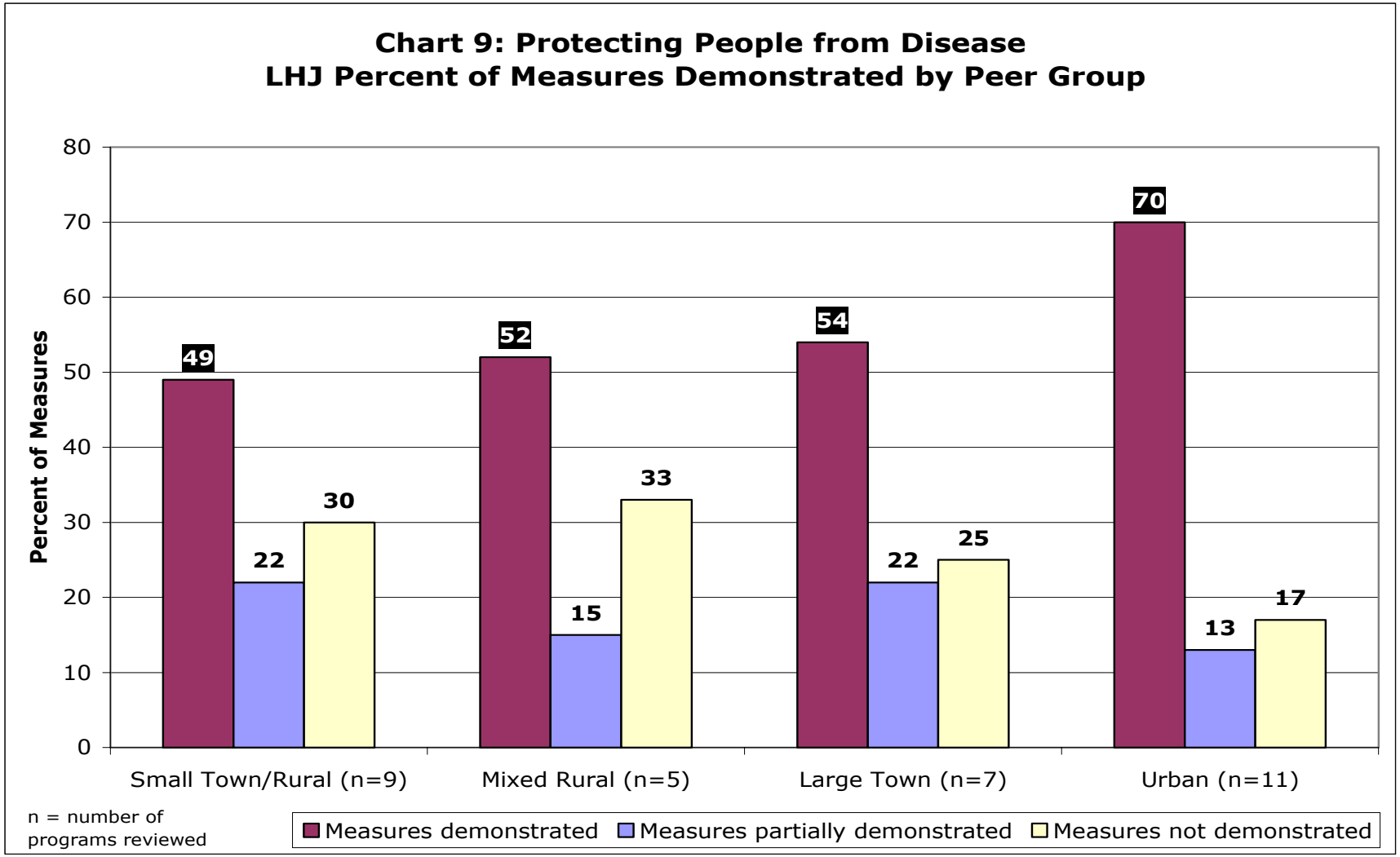
Some *small town/rural* LHJs demonstrated higher overall performance than some *urban* LHJs. This variability indicates that performance, while correlated to size, also has other drivers. Although there is no quantitative data, field observation suggests: local priority setting; leadership; local funding levels; staff skill, training and experience; and documentation and data systems.



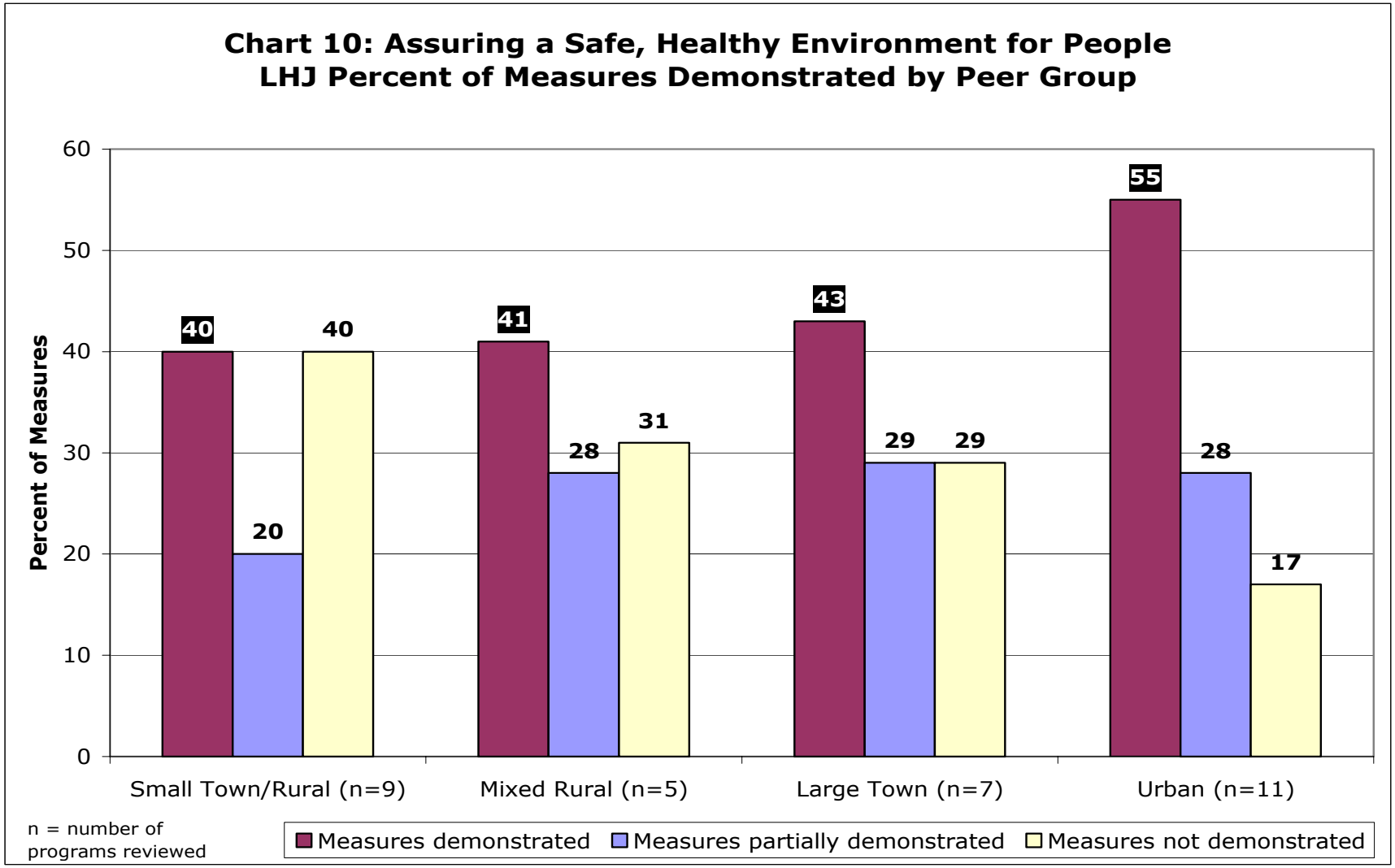
Note: These percentages are ***not percent of LHJs*** demonstrating performance. They are the ***percent of measures*** where LHJs were able to demonstrate performance.



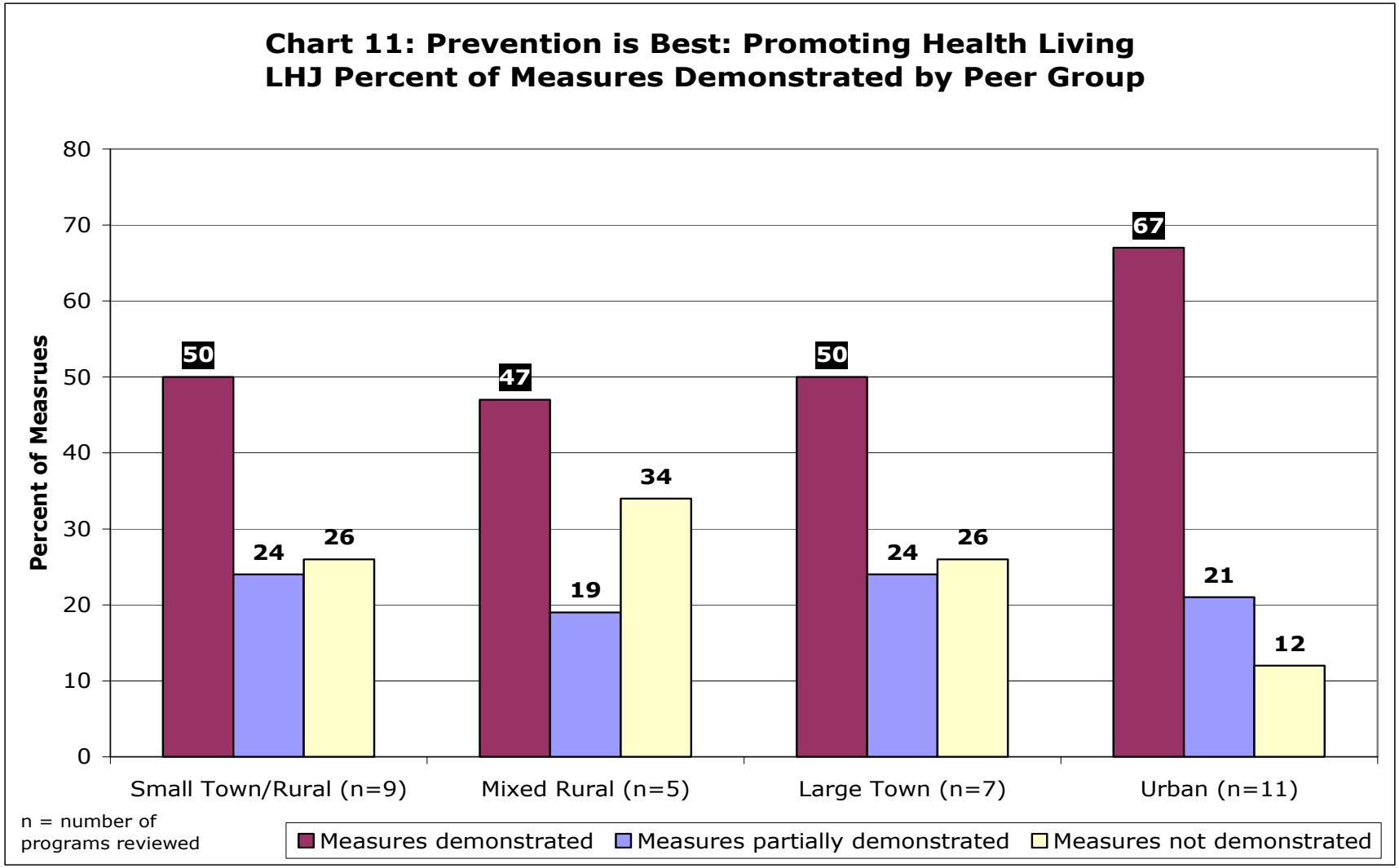
Note: These percentages are ***not percent of LHJs*** demonstrating performance. They are the ***percent of measures*** where LHJs were able to demonstrate performance.



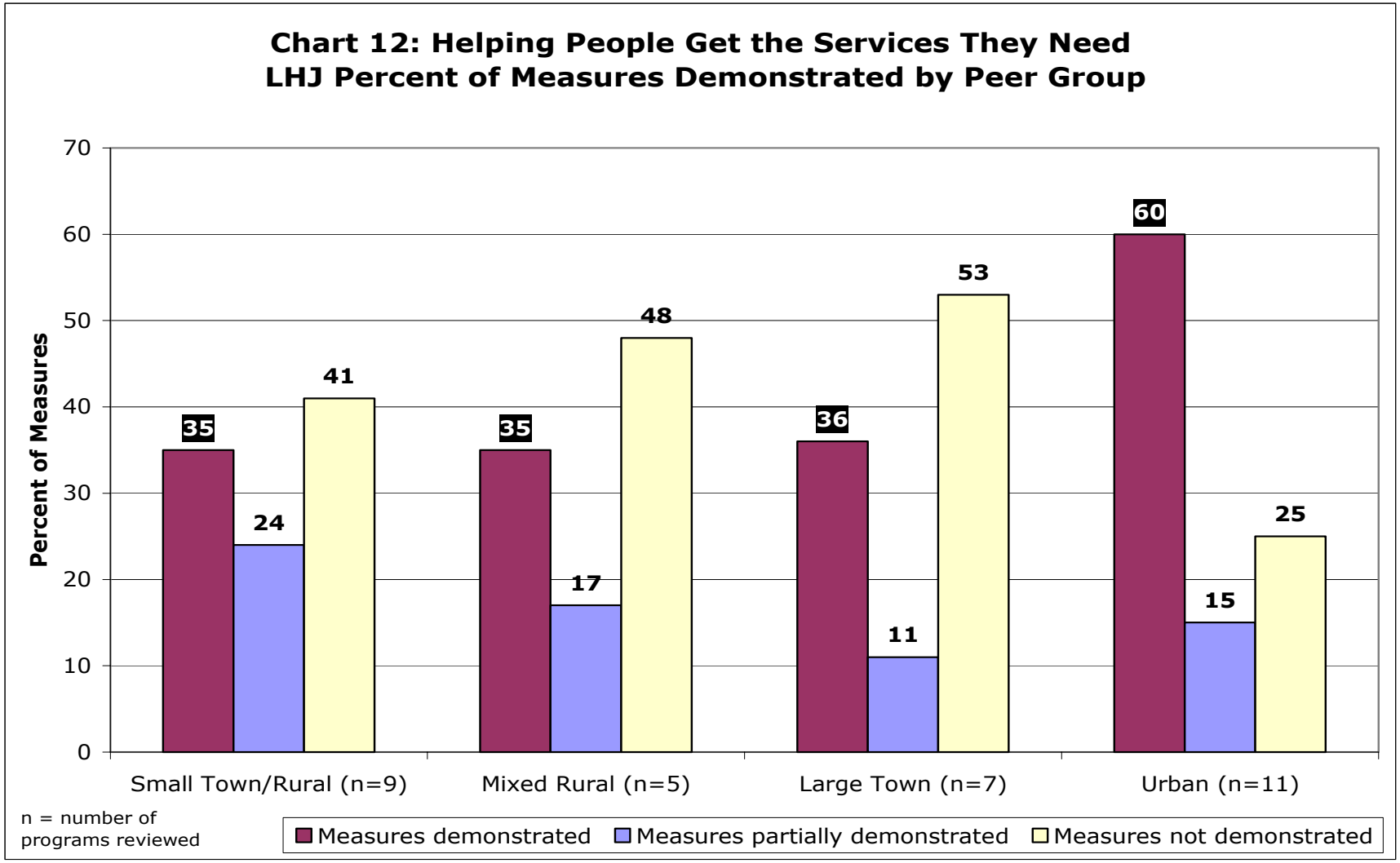
Note: These percentages are ***not percent of LHJs*** demonstrating performance. They are the ***percent of measures*** where LHJs were able to demonstrate performance.



Note: These percentages are ***not percent of LHJs*** demonstrating performance. They are the ***percent of measures*** where LHJs were able to demonstrate performance.



Note: These percentages are ***not percent of LHJs*** demonstrating performance. They are the ***percent of measures*** where LHJs were able to demonstrate performance.



Note: These percentages are ***not percent of LHJs*** demonstrating performance. They are the ***percent of measures*** where LHJs were able to demonstrate performance.

D. State Programs: Overall Performance

For each DOH program, only some measures were applicable; the applicability was based on the matrix developed by DOH in advance of the site reviews. The site reviewers tested the matrix and have submitted a proposed revision to DOH for their review and adoption (see Attachment G). In order for DOH programs to be clear about their accountability under the standards, they need to know, from this point forward, what standards they should prepare for in future cycles.

As noted in the overall system discussion, not all programs managed by DOH are implemented by LHJs. In some instances, DOH programs may work with community-based agencies, depending on the community arrangement (e.g., WIC, Family Planning). In other instances, the work (e.g., Genetics, Radiation) is with other partners and the measures need to be "translated" to be applicable in regard to working with other community stakeholders.

The charts in Attachment B provide detailed information by standard and measure, for DOH programs. Chart 13 provides a summary for all of DOH, by topic area.

There were numerous measures where 95% or more of DOH programs were able to fully demonstrate performance. There were also ten measures where fewer than 5% of DOH programs were able to fully demonstrate performance; for many of these there was no program able to demonstrate performance. These are noted in the discussion that follows.

1. Standards for Public Health Assessment

For the vast majority of measures in this topic area (21 of 22 measures), at least 50% or more of the applicable state programs demonstrate performance. In many instances, 100% of the state programs demonstrated performance. The exception (4.4.2) indicates an area of needed improvement around the issue of:

- Providing a written protocol for using health assessment information to guide health policy decisions

2. Standards for Communicable Disease and Other Health Risks

For three quarters of the measures in this topic area (20 of 26 measures), at least 50% or more of the applicable state programs demonstrated performance. The exceptions (1.54, 2.4.3, 3.5.3, 4.5.4, 5.4.2, and 5.8.6) indicate areas of needed improvement around the issues of:

- Ensuring annual goals and objectives are a part of the DOH planning process
- Providing written procedures that describe lab capacity for needed outbreak response
- Ensuring an annual evaluation of a sample of state communicable disease investigations is done to monitor timeliness and compliance with protocols

- Ensuring that future goals address communication issues identified in outbreak response evaluations
- Providing model plans, protocols, evaluation, and a debriefing process for responses to outbreaks

In regard to the first four areas of needed improvement (Standard 1: *Quality measures that address the capacity, process for delivery and outcomes of critical health services are established, monitored, and reported*, Standard 2: *Response plans delineate roles and responsibilities in the event of communicable disease outbreaks and other health risks that threaten the health of people*, Standard 3: *Communicable disease investigation and control procedures are in place and actions documented*, & Standard 4: *Urgent public health messages are communicated quickly and clearly and actions documented*) none of the DOH programs fully demonstrated these measures. In fact, for measures 1.5.4, 3.5.3, and 4.5.4, none of the DOH programs demonstrated the measure at all.

3. Standards for Assuring a Safe, Healthy Environment for People

At least 50% or more of the applicable state programs were found to demonstrate performance with just over half of the measures in this topic area (12 of 20 measures). The exceptions (1.5.3, 1.4.4, 1.6.5, 2.2.2, 2.4.3, 2.7.5, 3.8.3 and 4.4.4) indicate areas of needed improvement around the issues of:

- Developing plans for environmental health education
- Evaluating emergency response plans and ensuring that all staff are trained in the use of these plans
- Ensuring that a quality improvement plan includes consideration of analysis of environmental health information, trends, and debriefings
- Ensuring that regulatory programs are reviewed and that the review is documented

In Standard 1 (*Environmental health education is a planned component of public health programs*) only half of the measures had demonstrated performance at 50% or more. This emphasizes the need for developing plans for environmental health education. Emphasis on evaluating emergency response plans is also important. For Standard 2 (*Services are available throughout the state to respond to environmental events or natural disasters that threaten the public's health*), three out of five measures had less than 50% demonstration. In fact, only 8.57% of the DOH programs fully demonstrated that staff are trained in the use the emergency response plans. For Standard 3 (*Both environmental health risks and environmental health illnesses are tracked, recorded, and reported*) no program fully demonstrated that they had developed a quality improvement plan (measure 3.8.3).

4. Standards for Prevention and Community Health Promotion

For more than two-thirds of the measures in this topic area (16 of 23 measures), at least 50% or more of the applicable state programs demonstrate performance. The exceptions (1.8.4, 2.7.5, 3.5.2, 4.2.1, 4.4.2, 4.5.3, and 5.7.5) indicate areas of needed improvement around the issues of:

- Ensuring there is a statewide prevention plan that is evaluated and revised regularly
- DOH staff members have training in community mobilization methods

- Ensuring prevention programs are evaluated against performance measures are integrated into the priority setting process
- Providing technical assistance on program implementation to the LHJs
- Ensuring prevention interventions are reviewed for compliance with science and professional standards, and that they have performance measures that are tracked and analyzed
- Ensuring DOH staff has training in health promotion methods

Two standards in this topic area should be focused on more heavily. In regard to staff members having training in community mobilization methods (Standard 2: *Active involvement of community members is sought in addressing prevention priorities*) no DOH programs fully demonstrated this measure. In regard to ensuring technical assistance to LHJs and ensuring prevention interventions are in compliance with science (Standard 4: *Prevention, early intervention and outreach services are provided directly or through contracts*) these measures were demonstrated by less than 50% of DOH programs.

5. Standards for Access to Critical Health Services

Just over half of the measures in this topic area (8 of 13 measures) were demonstrated by 50% or more of DOH programs. The exceptions (1.6.1, 2.4.2, 2.7.4, 4.7.2, and 4.8.3) indicate areas of needed improvement around issues of:

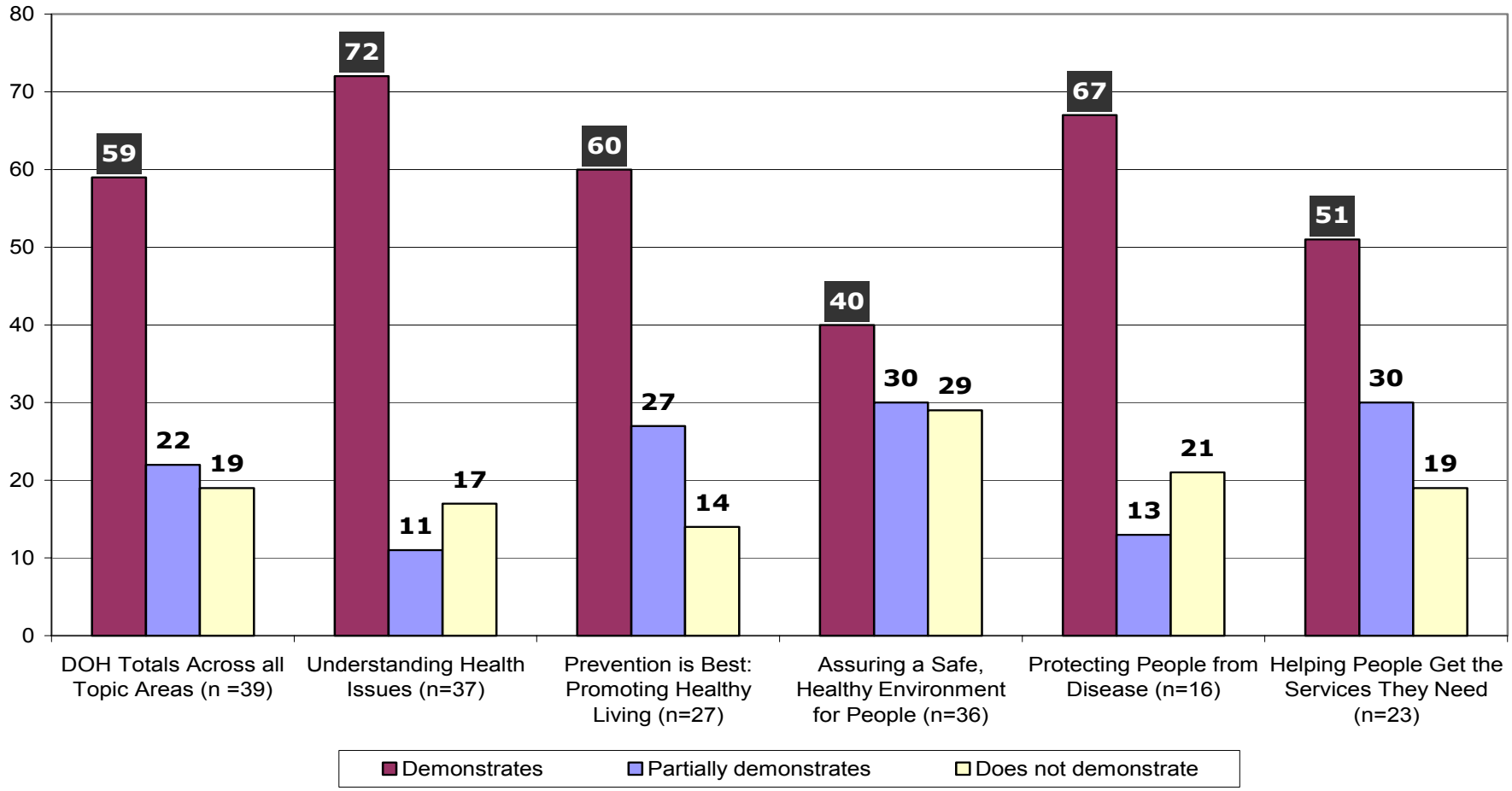
- Providing information to LHJs and other agencies about availability of licensed health care providers and other supports
- Providing written procedures for obtaining technical assistance for LHJs in gathering information on barriers to access
- Ensuring periodic studies on workforce needs
- Ensuring that training on quality improvement methods is available and incorporated into grant and program requirements
- Providing a quality improvement plan for all regulatory and clinical services administered by DOH

Providing information to LHJs about the availability of health care providers and ensuring periodic studies on workforce needs are two areas of strong focus. No programs were able to fully demonstrate these measures (1.6.1 & 2.7.4). However, in regard to Standard 2 (*Available information is used to analyze trends which, over time, affect access to critical health services*), in this topic area all measures were fully met by at least 50% of the DOH programs.

6. Summary of Performance Demonstrated: State Programs

In the aggregate across all DOH programs, measures and topic areas, DOH demonstrated performance on 59% of the measures. This is the "roll up" average of the percent of measures where DOH programs were able to fully demonstrate performance. This aggregate level falls below 50% in the Environmental Health topic area.

Chart 13: Overall DOH Percent of Measures Demonstrated by Topic Area



Note: These percentages are ***not percent of DOH programs*** demonstrating performance. They are the ***percent of measures*** where DOH programs were able to demonstrate performance.

E. Relationship of Performance to Peer Group, Annual Budgets and Number of Employees

Each LHJ was asked to provide current budget and FTE information, distributed by the five topic areas. If they were able to project the budget and FTEs needed to fully demonstrate the Standards, or the impact of reductions in funding, by topic area, this was collected. This information will be summarized and provided to the Finance Committee. The table at the end of this analysis summarizes the current level budget and FTEs by peer grouping.

1. Peer Group

In general, peer group was not significantly related to demonstration of most measures. However, for the following measures the urban and mixed rural peer groups were significantly more likely to demonstrate the measures:

- AS L 2.3.2: *The Board of Health receives information on local health indicators at least annually.*
- AS L 3.3.1: *The annual report to the BOH includes progress toward program goals.*
- EH L 1.2.2: *There are documented processes for involving community members and stakeholders in addressing environmental health issues including education and the provision of technical assistance.*

In addition, the *urban* peer group was significantly more likely to demonstrate the following measures:

- AS L 1.5.3: *Goals and objectives are established for assessment activities as a part of LHJ planning, and staff or outside assistance is identified to perform the work.*
- AS L 2.4.3: *Assessment procedures describe how population level investigations are carried out for documented or emerging health issues and problems.*
- AS L 2.5.4: *Assessment investigations of changing or emerging health issues are part of the LHJ's annual goals and objectives.*
- AS L 3.5.3: *Program performance measures are monitored, the data is analyzed, and regular reports document the progress towards goals.*
- AS L 4.5.4: *Key indicator data and related recommendations are used in evaluating goals and objectives.*
- CD L 1.1.1: *Information is provided on how to contact the LHJ to report a public health concern 24 hours per day. Law enforcement has current local and state 24-hour emergency contact lists.*
- EH L 1.6.4: *The environmental health education plan identifies performance measures for education programs. There is an evaluation process for health education offerings that is used to revise curricula.*
- PP L 5.5.3: *Health promotion efforts have goals, objectives and performance measures. The number and type of health promotion activities are tracked and reported, including information on content, target audience, number of attendees. There is an evaluation process for health promotion efforts that is used to improve programs or revise curricula.*

2. Annual Budgets

An assumption has been made by many that those jurisdictions with larger budgets would be better able to demonstrate the measures. Analysis shows that jurisdictions with larger budgets were found to be more likely to demonstrate (or partially demonstrate) 28 of the 98 LHJ measures (29%):

Public Health Assessment (4 of 24 measures)

- AS L 1.4.2: *There is a written procedure describing how and where to obtain technical assistance on assessment issues.*
- AS L 3.3.1: *The annual report to the BOH includes progress toward program goals.*
- AS L 4.4.3: *There is a written protocol for developing recommendations for action using health assessment information to guide health policy decisions.*
- AS L 5.7.4: *Employees are trained regarding confidentiality, including those who handle patient information and clinical records, as well as those handling data.*

Communicable Disease and other Health Risks (7 of 26 measures)

- CD L 1.1.1: *Information is provided on how to contact the LHJ to report a public health concern 24 hours per day. Law enforcement has current local and state 24-hour emergency contact lists.*
- CD L 1.2.2: *Health care providers and laboratories know which diseases require reporting, have timeframes, and have 24-hour local contact information. There is a process for identifying new providers in the community and engaging them in the reporting process.*
- CD L 1.3.3: *The local BOH receives an annual report, one element of which summarizes communicable disease surveillance activity.*
- CD L 1.4.4: *Written protocols are maintained for receiving and managing information on notifiable conditions. The protocols include role-specific steps to take when receiving information as well as guidance on providing information to the public.*
- CD L 1.5.5: *Communicable disease key indicators and implications for investigation, intervention or education efforts are evaluated annually.*
- CD L 2.1.1: *Phone numbers for weekday and after-hours emergency contacts are available to DOH and appropriate local agencies, such as schools and public safety.*
- CD L 4.4.3: *Roles are identified for working with the news media. Policies identify the timeframes for communication and the expectations of all staff regarding information sharing and response to questions, as well as the steps for creating and distributing clear and accurate public health alerts and media releases.*

Assuring a Safe, Healthy Environment for People (9 of 18 measures)

- EH L 1.1.1: *Information is available about environmental health educational programs through brochures, flyers, newsletters, websites and other mechanisms.*
- EH L 1.2.2: *There are documented processes for involving community members and stakeholders in addressing environmental health issues including education and the provision of technical assistance.*
- EH L 1.5.3: *A plan for environmental health education exists and includes goals, objectives and learning outcomes.*
- EH L 1.6.4: *The environmental health education plan identifies performance measures for education programs. There is an evaluation process for health education offerings that is used to revise curricula.*
- EH L 2.1.1: Information *is provided to the public on how to report environmental health threats or public health emergencies, 24 hours a day; this includes a phone number.*
- EH L 2.2.2: *Appropriate stakeholders are engaged in developing emergency response plans. Following an emergency response to an environmental health problem or natural*

disaster, stakeholders are convened to review how the situation was handled, and this debriefing is documented with a written summary of findings and recommendations.

- EH L 2.5.4: *There is a plan that describes LHJ internal roles and responsibilities for environmental events or natural disasters that threaten the health of the people. There is a clear link between this plan and other local emergency response plans.*
- EH L 3.6.2: *A surveillance system is in place to record and report key indicators for environmental health risks and related illnesses. Information is tracked and trended over time to monitor trends. A system is in place to assure that data is shared routinely to local, state and regional agencies.*
- EH L 3.8.3: *A quality improvement plan includes consideration of environmental health information and trends, findings from public input, evaluation of health education offerings, and information from compliance activity.*

Prevention and Community Health Promotion (6 of 19 measures)

- PP L 1.2.1: *Prevention and health promotion priorities are selected with involvement from the BOH, community groups and other organizations interested in the public's health.*
- PP L 1.5.3: *Prevention and health promotion priorities are reflected in the goals, objectives and performance measures of the LHJ's annual plan. Data from program evaluation and key indicators is used to develop strategies.*
- PP L 3.6.2: *Local prevention services are evaluated and a gap analysis that compares existing community prevention services to projected need for services is performed periodically and integrated into the priority setting process.*
- PP L 3.8.5: *A quality improvement plan incorporates program evaluation findings, evaluation of community mobilization efforts, use of emerging literature and best practices and delivery of prevention and health promotion services.*
- PP L 4.7.4: *Staff providing prevention, early intervention or outreach services have appropriate skills and training as evidenced by job descriptions, resumes or training documentation.*
- PP L 5.5.3: *Health promotion efforts have goals, objectives and performance measures. The number and type of health promotion activities are tracked and reported, including information on content, target audience, number of attendees. There is an evaluation process for health promotion efforts that is used to improve programs or revise curricula.*

Access to Critical Health Services (2 of 11 measures)

- AC L 1.5.3: *The list of critical health services is used along with assessment information to determine where detailed documentation of local capacity is needed.*
- AC L 2.5.2: *Gaps in access to critical health services are identified using periodic survey data and other assessment information.*

3. Number of Employees

As with budgets, it has been assumed that jurisdictions with more employees would be better able to demonstrate the measures. Analysis shows that jurisdictions with more employees were found to be more likely to demonstrate (or partially demonstrate) 25 of the 98 LHJ measures (26%):

Public Health Assessment (5 of 24 measures)

- AS L 2.5.4: *Assessment investigations of changing or emerging health issues are part of the LHJ's annual goals and objectives.*
- AS L 3.3.1: *The annual report to the BOH includes progress toward program goals.*
- AS L 4.4.3: *There is a written protocol for developing recommendations for action using health assessment information to guide health policy decisions.*
- AS L 5.4.3: *All program data are submitted to local, state, regional and federal agencies in a confidential and secure manner.*
- AS L 5.7.4: *Employees are trained regarding confidentiality, including those who handle patient information and clinical records, as well as those handling data.*

Communicable Disease and other Health Risks (5 of 26 measures)

- CD L 1.1.1: *Information is provided on how to contact the LHJ to report a public health concern 24 hours per day. Law enforcement has current local and state 24-hour emergency contact lists.*
- CD L 1.5.5: *Communicable disease key indicators and implications for investigation, intervention or education efforts are evaluated annually.*
- CD L 2.1.1: *Phone numbers for weekday and after-hours emergency contacts are available to DOH and appropriate local agencies, such as schools and public safety.*
- CD L 2.4.3: *Written policies or procedures delineate specific roles and responsibilities within agency divisions for local response and case investigations of disease outbreaks and other health risks.*
- CD L 4.4.3: *Roles are identified for working with the news media. Policies identify the timeframes for communication and the expectations of all staff regarding information sharing and response to questions, as well as the steps for creating and distributing clear and accurate public health alerts and media releases.*

Assuring a Safe, Healthy Environment for People (7 of 18 measures)

- EH L 1.2.2: *There are documented processes for involving community members and stakeholders in addressing environmental health issues including education and the provision of technical assistance.*
- EH L 1.5.3: *A plan for environmental health education exists and includes goals, objectives and learning outcomes.*
- EH L 1.6.4: *The environmental health education plan identifies performance measures for education programs. There is an evaluation process for health education offerings that is used to revise curricula.*
- EH L 2.1.1: *Information is provided to the public on how to report environmental health threats or public health emergencies, 24 hours a day; this includes a phone number.*
- EH L 2.2.2: *Appropriate stakeholders are engaged in developing emergency response plans. Following an emergency response to an environmental health problem or natural disaster, stakeholders are convened to review how the situation was handled, and this debriefing is documented with a written summary of findings and recommendations.*
- EH L 3.6.2: *A surveillance system is in place to record and report key indicators for environmental health risks and related illnesses. Information is tracked and trended over time to monitor trends. A system is in place to assure that data is shared routinely to local, state and regional agencies.*

- EH L 3.8.3: *A quality improvement plan includes consideration of environmental health information and trends, findings from public input, evaluation of health education offerings, and information from compliance activity.*

Prevention and Community Health Promotion (6 of 19 measures)

- PP L 1.2.1: *Prevention and health promotion priorities are selected with involvement from the BOH, community groups and other organizations interested in the public's health.*
- PP L 1.5.3: *Prevention and health promotion priorities are reflected in the goals, objectives and performance measures of the LHJ's annual plan. Data from program evaluation and key indicators is used to develop strategies.*
- PP L 3.6.2: *Local prevention services are evaluated and a gap analysis that compares existing community prevention services to projected need for services is performed periodically and integrated into the priority setting process.*
- PP L 4.7.4: *Staff providing prevention, early intervention or outreach services have appropriate skills and training as evidenced by job descriptions, resumes or training documentation.*
- PP L 5.4.2: *Procedures describe an overall system to organize, develop, distribute, evaluate, and update health promotion materials. Technical assistance is provided to community organizations, including "train the trainer" methods.*
- PP L 5.5.3: *Health promotion efforts have goals, objectives and performance measures. The number and type of health promotion activities are tracked and reported, including information on content, target audience, number of attendees. There is an evaluation process for health promotion efforts that is used to improve programs or revise curricula.*

Access to Critical Health Services (2 of 11 measures)

- AC L 1.1.1: *Up-to-date information on local critical health services is available for use in building partnerships with community groups and stakeholders.*
- AC L 1.5.3: *The list of critical health services is used along with assessment information to determine where detailed documentation of local capacity is needed.*

4. Per Capita Funding and Per Capita Staffing

Another way of looking at the issue of funding and its relationship to demonstrating the measures is to think of funding in terms of per capita dollars. Analysis shows that the following measures were more likely to be demonstrated (or partially demonstrated), the higher the per capita dollars:

- AS L 1.5.3: *Goals and objectives are established for assessment activities as a part of LHJ planning, and staff or outside assistance is identified to perform the work.*
- AS L 2.2.1: *Assessment data is provided to community groups and representatives of the broader community for review and identification of emerging issues that may require investigation.*
- CD L 1.3.3: *The local BOH receives an annual report, one element of which summarizes communicable disease surveillance activity.*
- CD L 2.1.1: *Phone numbers for weekday and after-hours emergency contacts are available to DOH and appropriate local agencies, such as schools and public safety.*
- CD L 4.4.3: *Roles are identified for working with the news media. Policies identify the timeframes for communication and the expectations of all staff regarding information*

sharing and response to questions, as well as the steps for creating and distributing clear and accurate public health alerts and media releases.

- CD L 5.4.3: *Local protocols are revised based on local review findings and model materials disseminated by DOH.*
- CD L 5.7.5: *Staff training in communicable disease and other health risk issues is documented.*
- EH L 1.5.3: *A plan for environmental health education exists and includes goals, objectives and learning outcomes.*
- EH L 4.5.3: *There is a documented process for periodic review of enforcement actions.*
- EH L 4.6.4: *An environmental health tracking system enables documentation of the initial report, investigation, findings, enforcement, and subsequent reporting to other agencies as required.*
- AC L 1.5.3: *The list of critical health services is used along with assessment information to determine where detailed documentation of local capacity is needed.*

Similarly, when relationships between measure demonstration and per capita staffing were analyzed, those with higher per capita staffing levels were more likely to demonstrate (or partially demonstrate) the following measures:

- AS L 1.2.1: *Current information on health issues affecting the community is readily accessible, including standardized quantitative and qualitative data.*
- AS L 5.2.1: *Community members and stakeholders that receive data have demonstrated agreement to comply with confidentiality policies and practices, as appropriate.*
- CD L 3.4.3: *Communicable disease protocols require that investigation begin within 1 working day, unless a disease-specific protocol defines an alternate time frame.*
- CD L 5.8.6: *A debriefing process for review of response to public health threats or disease outbreaks is included in the quality improvement plan and includes consideration of surveillance, staff roles, investigation procedures, and communication.*
- AC L 1.5.3: *The list of critical health services is used along with assessment information to determine where detailed documentation of local capacity is needed.*

5. Threshold Analysis

A scatter diagram threshold analysis suggests that those LHJs with a budget of $7 million or more and/or 70 or more FTEs consistently demonstrate higher performance. A related analysis looked at the characteristics of the LHJs scoring above the 60th percentile. Having a budget level of $7 million and/or 70 FTEs is predictive of being in the group of eleven LHJs that demonstrated performance on more than 60% of the measures, supporting the scatter diagram findings.

However, despite these findings that correlate to budget or size, there is also variability among LHJs that is not connected to budget or size. Of the group of LHJs demonstrating performance on more than 60% of the measures, three are non-urban LHJs with budgets of around $2 million and less than 30 FTEs. What may be predictive of their performance is that each of them demonstrated more than 70% of the assessment measures (higher than all but one of their non-urban peers), as well as demonstrating 70% or better performance in one other topic area.

As noted earlier in the discussion of Overall System Performance, specific exemplary practices often reflected either locally focused resource allocation (for example,

targeted use of local capacity development funds or staff expertise) or state program structures and financing that focused efforts in program planning and evaluation—funding obviously made a difference. These specific exemplary practices were found in LHJs of all sizes, and were not necessarily related to overall performance or budget/FTE size. Also, as noted in the discussion regarding LHJ peer groups and the variability of performance, some small town/rural LHJs demonstrated higher overall performance than some urban LHJs. This variability indicates that performance also has other drivers. Although there is no quantitative data, field observation suggests: local priority setting; leadership; local funding levels; staff skill, training and experience; and, documentation and data systems.

In summary, while analysis gives us some predictive factors, it cannot be said with certainty that these factors are causative, nor does it identify other possible factors related to performance but not measured or observed in this analysis.

Table II: Annual Budget and FTEs by Peer Group

	Average LHJ Budget				Average LHJ FTE				LHJ FTE Range			
	Peer Group				Peer Group				Peer Group			
	Small Town / Rural	Mixed Rural	Large Town	Urban	Small Town / Rural	Mixed Rural	Large Town	Urban	Small Town / Rural	Mixed Rural	Large Town	Urban
Understanding Health Issues	$51,299	$97,003	$159,012	$953, 921	.68	1.01	1.33	9.68	.05-1.5	.27-2.5	.02-3.32	0-51
Protecting People from Disease	$111,195	$346,962	$474,141	$5,135,534	1.77	5.62	3.06	31.9	.2-3.21	.9-11.27	.37-10.5	10-149
Assuring a Safe, Healthy Environment*	$216,076	$760,759	$486,121	$5,177,284	3.56	12.84	7.46	43.8	0-8.05	7-18	3.75-15.5	5.63-121
Prevention is Best	$281,150	$366,315	$656,191	$3,473,230	4.23	9.07	10.07	43.58	.3-8.82	3.7-17	2-16.25	6.77-112.25
Helping People get the Services They Need **	$254,042	$44,491	$132,640	$111,020,257	2.63	.44	3.36	94.89	0-6.16	0-1.1	0-9	.21-888

* One site had no participation from EH, so no FTE information available (shown as 0). All other 0 s were provided by LHJs.

** Budget and FTEs includes the direct delivery of personal health services, supported by Medicaid and insurance billings

F. Key Management Practices

Detailed charts, by key management practice, by topic area, for LHJs and DOH are in Attachment B. Chart 6 from the Executive Summary is repeated here, as it summarizes overall performance on the key management practice areas. The system overall performs very well in the key management practices of Public Information and Community and Stakeholder Involvement. There is considerable variation in the other key management practices.

- LHJs are able to fully demonstrate measures relating to policies and procedures, or planning and evaluation in less than 40% of LHJ sites, while better than 50% of DOH programs are able to fully demonstrate these measures.
- Less than half of LHJ sites can fully demonstrate key indicators to measure and track, while almost 60% of DOH programs are able to do so, largely due to the recent production of The Health of Washington report.
- While LHJs are better able than DOH programs to document staff training efforts, as the recommendations discussion regarding training needs indicates, this often reflects just one person who has been trained.
- LHJs have few examples of quality or process improvement activities—these were fully demonstrated in just 20% of sites, and notably, there was no demonstration in over 50% of LHJ sites. DOH programs were better able to fully demonstrate process improvement activities—these, however, were programmatic and not part of any overall improvement approach within DOH. Review of the detailed charts show that DOH performance on the measures related to quality was strongest in the Assessment area, and variable across the other topic areas.

Other key management practice findings, based on the detailed charts, include:

- Local BOH involvement is least demonstrated in regard to the Access measures, with just 22% of LHJs able to fully demonstrate BOH involvement.
- Measures relating to policies and procedures in the Environmental Health topic area are fully demonstrated in only 16% of LHJs and 30% of DOH programs.
- LHJs can fully demonstrate measures relating to policies and procedures in the Assessment topic area in only 28% of sites, and in the Prevention topic area, 24% of sites.
- Program planning and evaluation measures are fully demonstrated by LHJs in the Communicable Disease topic area by only 19% of sites, and in the Environmental Health topic area, by 23% of sites. Similarly, DOH programs fully demonstrate program planning and evaluation measures for Communicable Disease in only 30% of programs and in Environmental Health, 29% of programs.

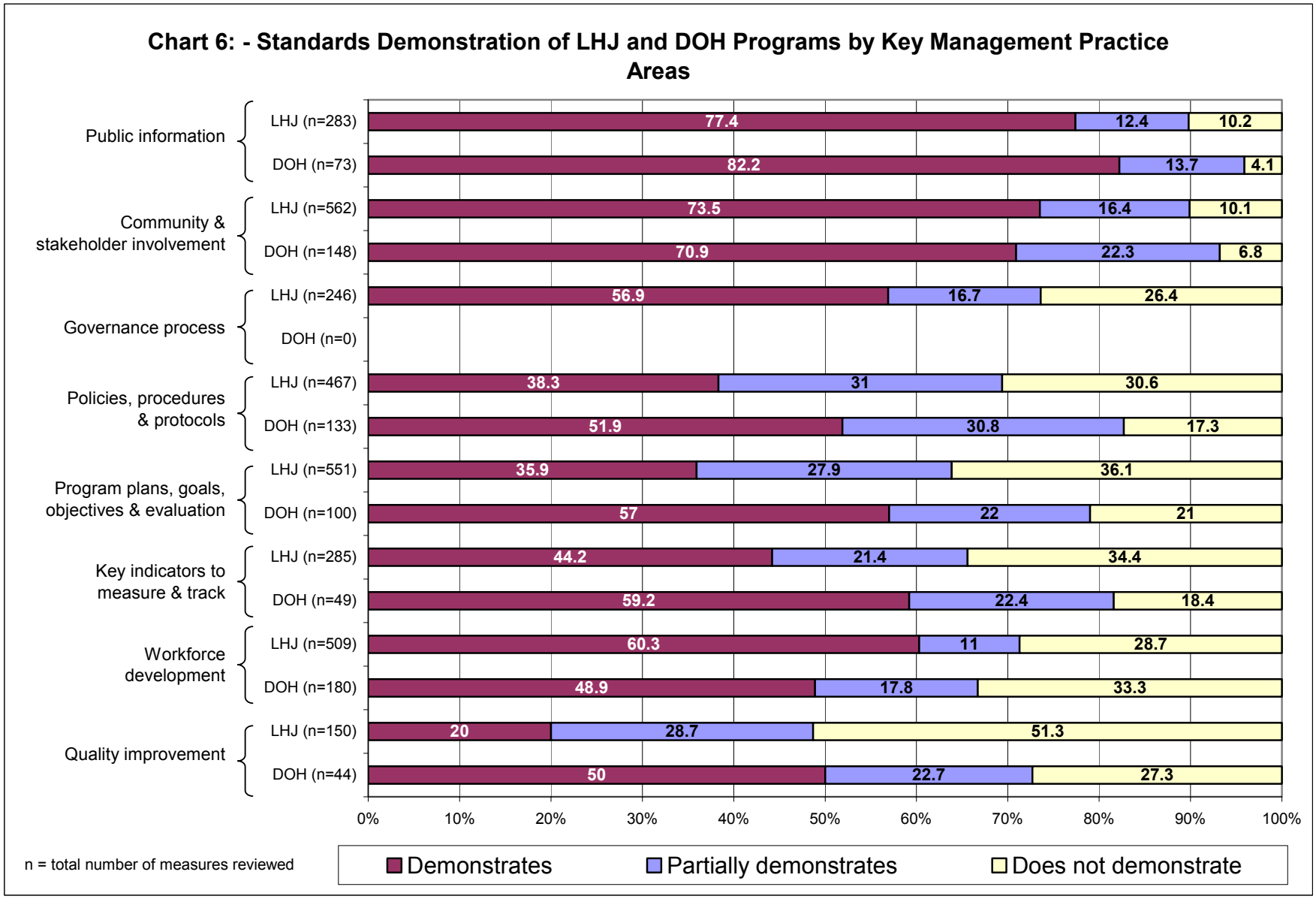


Chart 6: - Standards Demonstration of LHJ and DOH Programs by Key Management Practice Areas
Public information
LHJ (n=283)
77.4
12.4
10.2
DOH (n=73)
82.2
13.7
4.1
Community & stakeholder involvement
LHJ (n=562)
73.5
16.4
10.1
DOH (n=148)
70.9
22.3
6.8
Governance process
LHJ (n=246)
56.9
16.7
26.4
DOH (n=0)
Policies, procedures & protocols
LHJ (n=467)
38.3
31
30.6
DOH (n=133)
51.9
30.8
17.3
Program plans, goals, objectives & evaluation
LHJ (n=551)
35.9
27.9
36.1
DOH (n=100)
57
22
21
Key indicators to measure & track
LHJ (n=285)
44.2
21.4
34.4
DOH (n=49)
59.2
22.4
18.4
Workforce development
LHJ (n=509)
60.3
11
28.7
DOH (n=180)
48.9
17.8
33.3
Quality improvement
LHJ (n=150)
20
28.7
51.3
DOH (n=44)
50
22.7
27.3
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = total number of measures reviewed
Demonstrates
Partially demonstrates
Does not demonstrate

IV. Supports Needed to Improve Performance

As noted in the methodology discussion, the DOH and LHJ sites were asked to identify the supports and resources most needed to improve performance. The categories in the checklist below were created from qualitative analysis of interviews in the 2000 site reviews. In this baseline evaluation process, sites were asked to differentiate the supports needed by topic area, to further delineate the variation among the topic areas. The following discussion summarizes the checklist analysis and exit interview comments.

A. LHJ Supports and Resource Needs

The following table summarizes 29 LHJs responding with their top three needs; the table shows the five most frequent mentions by topic area.

Table III: LHJ Supports and Resources Needed: Top 3

	Assessment	Communicable Disease	Environmental Health	Prevention& Health Promotion	Access to Critical Health Services
More funding	X	X	X	X	X
Flexible funding	X	X	X	X	X
More staff	X	X	X	X	X
Specific staff skills	X	X			
Time to plan	X (tie)				X
Program planning process			X		X
Standard state databases					
Standard key indicators	X (tie)			X	
BOH/community involvement					
DOH consultation and templates					
Policy/ procedure templates		X	X		
Documentation methods/IT					
QI/program evaluation skills				X	
Role clarity					
Training					

B. DOH Supports and Resource Needs

The following table summarizes 36 DOH programs responding with their top three needs; the table shows the five most frequent mentions by topic area.

Table IV: DOH Supports and Resources Needed: Top 3

	Assessment	Communicable Disease	Environmental Health	Prevention & Health Promotion	Access to Critical Health Services
More funding	X	X (tie)	X	X	X
Flexible funding	X	X		X	X
More staff	X	X	X	X	X
Specific staff skills	X	X		X	
Time to plan		X (tie)	X		
Program planning process					
Standard state databases					
Standard key indicators	X				
BOH/community involvement					
DOH consultation and templates					
Policy/ procedure templates					
Documentation methods/IT					
QI/program evaluation skills			X	X	X
Role clarity					X
Training		X (tie)	X		

Chart 14 summarizes the responses across all topic areas, comparing LHJ and DOH responses.

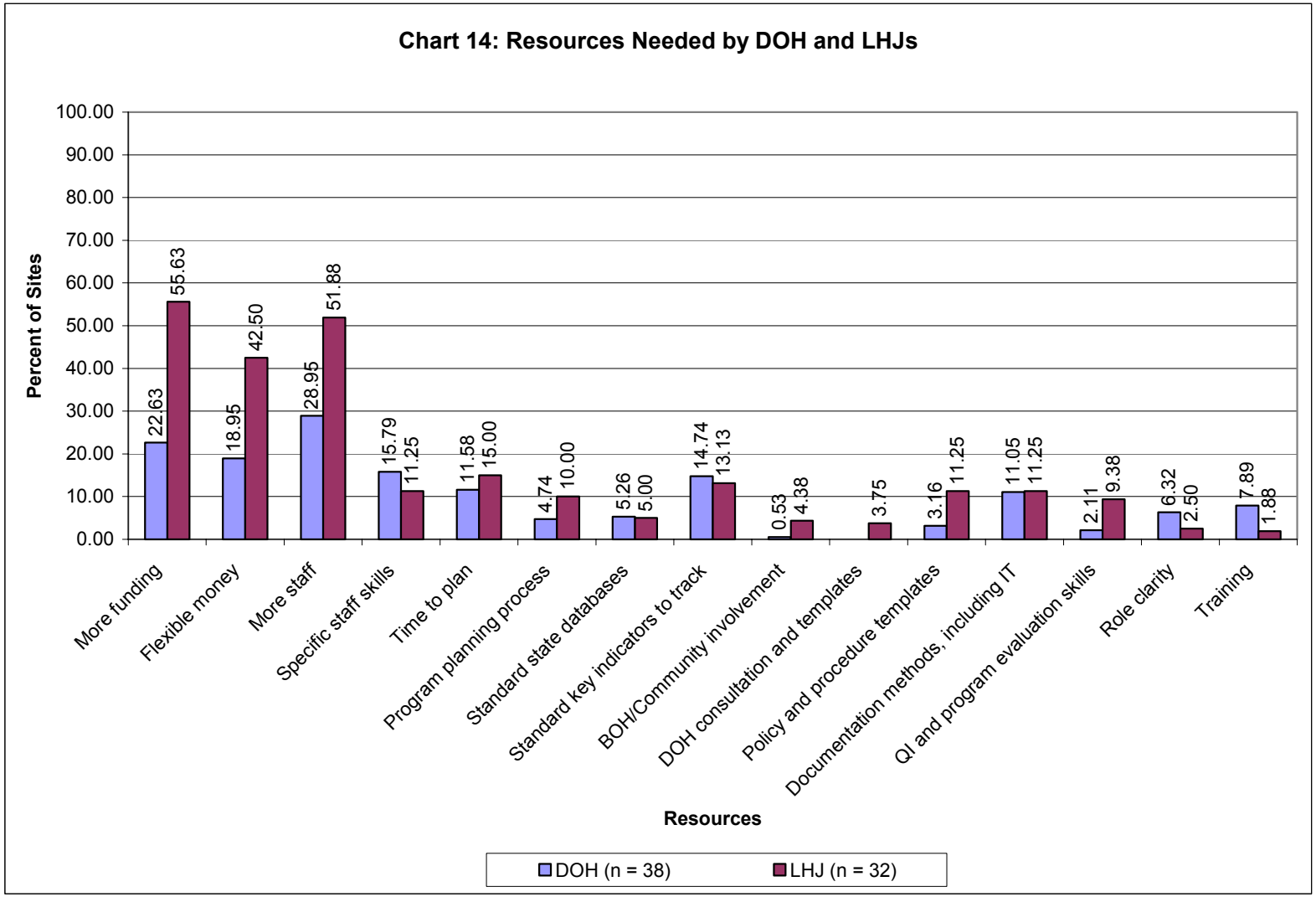


Chart 14: Resources Needed by DOH and LHJs
Percent of Sites
100.00
90.00
80.00
70.00
60.00
50.00
40.00
30.00
20.00
10.00
0.00
22.63
55.63
18.95
42.50
28.95
51.88
15.79
11.25
11.58
15.00
4.74
10.00
5.26
5.00
14.74
13.13
0.53
4.38
3.75
3.16
11.25
11.05
11.25
2.11
9.38
6.32
2.50
7.89
1.88
More funding
Flexible money
More staff
Specific staff skills
Time to plan
Program planning process
Standard state databases
Standard key indicators to track
BOH/Community involvement
DOH consultation and templates
Policy and procedure templates
Documentation methods, including IT
QI and program evaluation skills
Role clarity
Training
Resources
DOH (n = 38)
LHJ (n = 32)

C. *Discussion of Supports and Resources to Improve Performance*

1. Financing and staff

Not surprisingly, funding levels are at the top of everyone's list. DOH programs prioritized more and flexible funding as the major supports needed, as well as more staff to accomplish the work envisioned in the standards.

LHJ sites also prioritized the need for more funding and staff, as well as flexibility in funding. Currently, state or federal programmatic funding drives the ability to deliver most programs at the local level, regardless of established priorities, especially in the smaller jurisdictions. There is little room for flexibility, and as noted earlier, there is minimal earmarked state or local funding for some of the basic work of public health as outlined in the Standards, such as Assessment, Communicable Disease and Environmental Health. The site reviews captured the performance of the system as it faces further funding reductions, which challenged even the optimists about how to maintain current performance, much less improve on it.

Given enough staff and program resources, there are differences in what is needed for different topic areas within the standards, as noted below.

2. Specific staff skills

DOH staff identified specific staff skills as important for meeting the standards in the Assessment, Communicable Disease and Prevention and Health Promotion topic areas. LHJs echoed the need for skills in Assessment and Communicable Disease.

3. Time to plan

Time to plan was prioritized by DOH programs for both the Communicable Disease and Environmental Health topic areas. LHJs looked for more time to plan in the areas of Assessment and Access to Critical Health Services

4. Program planning process

LHJs prioritized program planning processes for Environmental Health and Access to Critical Health Services.

5. Standard key indicators to track

In order to make progress on the Assessment topic area, DOH programs and LHJs prioritized the development of standard key indicators to track.

6. Policy and procedure templates

LHJs prioritized the development of model templates for both Communicable Disease and Environmental Health.

7. QI/program evaluation skills

QI and program evaluation skills—the "closing the loop" of the PDCA cycle—were prioritized by DOH programs for the Environmental Health, Prevention and Health

Promotion and Access to Critical Health Services topic areas. LHJs noted this need in other areas, but prioritized it for the Prevention and Health Promotion area.

8. Role clarity

Role clarity was prioritized for the Access topic area by DOH programs.

9. Training

Training for staff was prioritized by DOH programs for both the Communicable Disease and Environmental Health topic areas.

V. Recommendations: Developing the Supports Needed

A. Financing and Staff

As noted earlier, the findings of the baseline evaluation represent demonstrated ability in the program areas selected by the sites as their examples—there are many other program areas where the measures would not be demonstrated. And, the best examples come from program areas that were either provided structure and resources to develop program operations—"We have that front desk manual because our Family Planning grant required us to have one!"—or because a decision was made to focus local capacity development funding or local/regional funding on specific initiatives. The obvious conclusion: system improvement gets done when there are resources and staff, as well as requirements. Or, requiring improvements without providing resources, especially for core work, cannot obtain the results that the overall system needs to have in place.

The process of prioritizing the supports and resources needed resulted in considerable feedback regarding the need for flexible resources that can be used to address the issues identified in the local population through the assessment process, and to build program capacity in core functions.

The current public financing environment is very challenging. The bioterrorism discussion puts the spotlight on public health but skews attention to the potential large scale issues rather than the daily work of the public health system. However, many of the measures that are not well demonstrated should be addressed as a part of bioterrorism planning and they will serve the system every day as well.

B. Specific Staff Skills

Many DOH and LHJ leaders described the need to find public health staff that can come to the job prepared to do the work, especially in the non-urban jurisdictions. Among the supports related to staffing, consider:

- Develop an HR plan that describes the professional requirements for an effective health education and promotion staff, whether employed by DOH or LHJs, and create recruitment strategies for the system. Many LHJs noted that they have restructured work as a strategy to deal with the shortage of RNs in the healthcare system, pulling out of RN duties the components that can be provided by health educators, and recruiting for these new positions.

- Similarly, skills in assessment, epidemiology, analysis and program evaluation were mentioned frequently by DOH and LHJ sites; these skills can be particularly difficult to find in non-urban jurisdictions.

On a related note, there seems to be a substantial cohort of new Health Officers in LHJs since the 2000 site reviews. They come to these positions with skills and experience gained from other healthcare settings, and many have MPH as well as MD degrees. Their vision and energy represent a system opportunity, especially in regard to adoption of exemplary practices and model protocols and policies—this is a set of staff skills to capitalize upon.

C. Time to Plan

This, most agreed, is a function of having enough staff to deliver the direct services,. In smaller jurisdictions, many managers are also direct service providers; additional staff would give them time to assess, think, evaluate, plan and oversee implementation of new efforts. The current lack of planning and management time is directly related to some of the gaps in demonstrated performance.

D. Program Planning Processes

In many LHJs, the examples that demonstrated performance on the measures were from DOH or other state programs that have structured their approach to planning and program evaluation, requiring goals and objectives, measurement of indicators, evaluation and reporting (for example, Family Planning, WIC, HIV, Community Mobilization Against Substance Abuse, IES Birth to Three, Breast and Cervical Cancer). Some programs specifically require quality components (Family Planning) or clear statements of the research basis for the work to be performed (HIV/AIDS).

Of course, each program's format is different, and few clearly cross-walked to what the measures look for—there is a significant opportunity here to reduce administrative demands on LHJs while supporting the development of infrastructure that is consistent for all programs and incorporating the standards into the everyday work of DOH programs and LHJs. Consider the following:

- Gather and evaluate the formats that are being used now by DOH and other state programs; identify those that have features consistent with the Standards (e.g., goals and objectives, science and assessment basis for the program goals and objectives, population targeted, measurement/indicators, a specific step of reviewing performance measure data and drawing conclusions for change or improvement of the program in the next period).
- Develop model templates (content requirements and format) for project applications, worksheets, program proposals, measurement, program evaluation and reporting that are consistent with and address the Standards and specific measures.
- To the extent possible (e.g., within the constraints of federal or other funding requirements), adopt the model templates in all DOH programs that contract with LHJs for services.
- Integrate this process into regional planning structures (e.g., HIV/AIDs).
- Develop multiprogram training sessions for LHJ staff, reducing the number of days away from their work to be trained by the multiple programs contracted by DOH.

- Assess whether program databases can be reconfigured to support these changes and also to provide access to data for LHJs—in some sites, staff are convinced that they cannot access the information about their own programs.

It was noted that health disparities are not systematically addressed in the Standards, although the issue of health disparities is embedded in the Access topic area and observed in many program specific goals and objectives. Consider how to systematically address this issue as a part of the model templates above.

Internal to DOH, the strategic planning process has provided a structured look at activities across the organization. Many programs provided feedback about creating more consistent processes that would help demonstrate the Standards, for example:

- Define the process for policy development, including rules and WAC coordination. Policies and priorities are established, but not always with consistent documentation of the decision-making process and criteria.
- Create better methods for talking about "what we should be doing" and develop a process to stop doing "things we don't need to do", in order to reassign staff and resources to assessing and planning for emerging priorities. This is also an issue for LHJs, who spoke about new "priority" work as simply being added to the existing work—leaving less time for any specific program. However, this conversation needs to be initiated at DOH prior to attempting to implement it locally.
- Related were comments about assuring a better connection between the use of data and the making of policy (also an issue for LHJs, but again, more appropriately dealt with first at DOH). It was observed that there should be a single DOH approach, which can then be applied in different program areas. It was also observed that, particularly in the area of Prevention and Health Promotion programs, there is not a linkage between assessment findings regarding priority needs of the Washington state population and the programs that are funded.

E. Standard State Databases

See the discussion under documentation and information technology below.

F. Standard Key Indicators to Track

At one LHJ site visit, someone asked, "Where is that secret list of key indicators referenced in the Standards?" Some DOH programs and LHJs have developed indicators, but many have not. The PHIP state level report card is targeted towards the public rather than serving as a management tool for the system. Some LHJs have done an outstanding job of using their assessment skills in the development of community report cards, but these are often broader in focus and, again, not useful as a management tool for the public health system. The exemplary practices report will provide some examples of indicators in use; the Florida system has a standard set of indicators for statewide use that would be a starting point for Washington.

Over the long term, performance on the Standards should be paired with a consistent set of indicators that provide numeric measurement and benchmarks. There is a strong sense that this work needs to be done statewide, not locally or program by program. One DOH participant observed, "Local jurisdictions were required to do the 1997 assessment reports, but then we failed to give them enough support for assessment to

become a tool for policy—and then decision makers made cuts in assessment staffing because they didn't see the value of the work".

DOH should lead a process, along with local assessment coordinators, to develop a simplified approach to standard key indicators (using the Florida model of a brief summary report rather than lengthy narrative descriptions). Consider the following steps:

- Look at the exemplary practice material to see what some sites are doing now.
- Create a list that includes data from a variety of sources in the current system (e.g., CD, EH, STDs, BRFSS).
- Document the data definitions for each indicator and the source of the data. Look for indicators that could also be benchmarked with other states.
- Narrow that to the basic list. The basic list would be developed for every LHJ. If some LHJs want to use the expanded list, that would be a local decision.
- Develop a simple template for the basic list. Attach the data definitions, sources of data and instructions for how and when to access the data in order to complete the local template.
- Pilot in LHJs of differing sizes and complexity. Get feedback and fine tune.
- Support LHJs' creation of final templates locally.
- Develop the capacity for DOH to provide a report to each LHJ that benchmarks their data to their peer group and statewide.

G. Boards of Health/Community Involvement

One of the strengths of the public health system in Washington is the extent of the community partnerships that have been built at both the state and local levels. This was observed throughout the site visit process. On the other hand, the involvement of local Boards of Health varies considerably; this is especially true regarding the review of data and the linkage between data and health policy. This suggests the development of statewide strategies to strengthen local BOH processes—the exemplary practices will be a starting point for this effort.

At the DOH level, the role of the State Board of Health was also raised, both in terms of their future participation as a part of site reviews, and in regard to the linkages between the BOH and DOH policy. This is also an area for consideration of role clarification.

H. DOH Consultation and Model Templates, Policies and Procedures

As with the discussion above regarding key indicators, there is considerable interest in developing model templates that can be adopted throughout the state. While RCWs and WACs provide the legal framework for some programs, there is a need to more clearly spell out in policy or protocol the "what" and "how" and "who" of daily implementation. Again, the exemplary practices report will provide the basis for moving forward, but specific work plans and assignments to groups and committees will be needed. Consider the following:

- Develop model templates for the basic components of environmental health education.
- Identify the policies and procedures that should be jointly developed by DOH and LHJs. Specific policies and procedures identified for joint development include:

    - Environmental health protocols for investigation and reporting
    - Communicable disease protocols for investigation and reporting
    - Evaluation/self-audit processes for communicable disease and environmental health investigation and outbreak management and debriefing
    - Procedures to develop, distribute, evaluate, and update health education and promotion information
    - Confidentiality policies
- Within DOH, focus on basic templates for DOH programs that address:
    - Process for LHJs to request consultation from state programs
    - Integration of health promotion and education efforts
    - Process for collecting and disseminating information statewide regarding community prevention and health promotion efforts
    - Process for informing agencies about health promotion funding opportunities
    - Review of health promotion interventions to determine how well they meet professional standards, federal and state requirements, and emerging science

I. Documentation Methods and Information Technology Systems

Standardize databases for clinical services, environmental health, and communicable disease tracking, and use the same data base throughout the local health jurisdictions; standardize systems for data collection, data gathering, and data analysis, including a surveillance system to receive, record, and report on environmental health indicators throughout the state. Specifically:

- There were many comments made about implementing PHIMS statewide as soon as possible.
- Develop a model template for interagency data sharing agreements.
- Create the ongoing and institutionalized measurement processes at the state level that are necessary to support LHJs in prioritizing community mobilization regarding critical health services access. Build on the work by the State Board of Health in regard to critical health services (list of services adopted September 2000) and measurement of access to critical health services by creating a report that is a companion to the Health of Washington report (which currently has some components of access tracking)—Indicators of Health Access in Washington.

J. QI/Program Evaluation Skills

DOH and LHJ sites indicated that development of skills in the areas of quality or process improvement and program evaluation were needed. In the site reviews, the measures that looked for training or skills in these areas found very few people system-wide. In addition to assuring that training is available, consider the following:

- Develop and disseminate a model process or template for doing process improvement in a cost efficient manner for use by both LHJs and DOH programs.
- Clarify the DOH process improvement process, its relationship to internal programs, LHJs, and the tracking of key indicators statewide.

K. Role Clarity

There continues to be considerable lack of clarity about, and discomfort with, the roles envisioned for both DOH and LHJs in regard to Access to Critical Health Services—even while there is agreement that the healthcare delivery system is in trouble and that access issues for the uninsured have been joined by access issues for Medicaid, Medicare, and in some instances, insured individuals. There are few exemplary practices to reference in this area, which suggests the need for further conceptualization regarding roles and tasks. If the major role of the public health system is community mobilization, as contrasted with becoming the provider of last resort, then the lack of useful data about access hampers effectiveness in the mobilization role. However, people also spoke to their concern that if the public health system begins monitoring these issues, it will be assumed that it is public health's job to do something about the issues, whereas it will take a much larger partnership to impact the healthcare delivery system.

In addition to working on role clarification in Access, the other comments regarding roles included:

- Develop DOH internal policies regarding roles and responsibilities for programs that address disease outbreaks, specifically describing the roles among Communicable Disease, Environmental Health and other DOH program areas (e.g., Immunization) and clarify respective roles regarding interaction with LHJs. Related to this, evaluate the causes of under and non-reporting of communicable diseases, by both providers and laboratories. Develop a statewide focus and strategies that support more consistent reporting.

L. Training

The findings on measures regarding workforce development over-represent the capacity of the system—if the measure sought evidence that DOH or LHJ staff had training in a certain skill (e.g., program evaluation) and one person's training was documented, the measure was scored as *demonstrates*. However, just as the best example from one program cannot be assumed as demonstrated in all programs, one person being trained is not the same as most or all persons being trained. System planning for training needs to address all staff and the fact that there is turnover in staff. From the documentation reviewed, it appears that some content areas were provided several years ago and have not been available again (e.g., quality, community mobilization, core functions).

In many cases LHJs do not have sufficient staff resources to train staff <u>and</u> to deliver services. Additional training and access to resources (such as funding for staffing coverage and attendance costs) is needed in all sizes of jurisdictions.

Training should be developed and offered periodically in each of the content areas identified in the key management practice of workforce development, across all topic areas.

- The staff skills and capacity to do quality improvement, program evaluation, community mobilization and health education and promotion have to be developed in addition to skills in providing traditional public health services.

- Regularly available training should also be available on the core functions of public health—this training was offered during a time of transition, but there are always new people coming into the system who don't have this knowledge base.
- Consider providing technical assistance, training and collaboration in a model that groups LHJs by like size rather than geography, so the agenda and curriculum is more closely aligned to the needs of those participating.
- Develop a data base template to document topic areas and track training participation for DOH staff (including training received off-site, at conferences, etc.) and provide as a template to LHJs.

Both DOH and the LHJs have work to do in consistently training staff regarding confidentiality and data security, as well as risk communication and emergency response plans. The current planning process for bioterrorism will require updated policies regarding data security, as well as upgrading of emergency response plans, so there are opportunities to bring the public health system's employees up to date on these issues.

In addition to training associated with public health skills and content, there are a series of ongoing activities related to the understanding the standards themselves. Initial recommendations were made following the training for this cycle of site visits. These recommendations were based on feedback and discussion at the trainings and are discussed below as a part of the interim work needed between now and the next cycle of site visits.

VI. Recommendations: The Standards Themselves

A. Topic Areas and Standards

There were no significant changes mentioned by site participants in regard to the topic areas or the standards themselves, although "fine tuning" was mentioned for some topic areas, such as Environmental Health. Because this has been a baseline evaluation, it is important to keep the current version of the Standards as stable as possible through the next cycle of site visits. Consequently, topic areas and standards should remain as written, and groups working on the issues outlined throughout these recommendation sections should document their suggestions for changes to be incorporated after the next site visit cycle.

The Standards Committee is currently drafting Standards for Administration, and several LHJs mentioned their support of this idea. The current draft overlaps the existing Standards in some areas, but other areas that are critical to system performance are missing from the existing Standards (for example, the Human Resource component). The draft Standards for Administration also require more detailed work on appropriate measures and application of key management practices. They should then be taken through a process similar to the adopted Standards: first, an on-paper field test in which LHJs and DOH report back on paper whether the measures make sense and can be documented. Based on that analysis, revise the draft and consider a site review field test before finalizing, either as a component of the next cycle of site reviews or as a stand-alone project. In either case, before final adoption, there should be a final crosswalk to

the adopted Standards, with duplicative ideas and materials removed from the adopted Standards. This should not occur, however, until after the next cycle of site reviews, in order to maintain stability in the measurement process. In the interim, a look at administrative indicators and benchmarks as part of future key indicators might prove to be productive, building on the work of the Finance Committee to identify the "drivers" in the system.

B. Measures

There were some areas of confusion and clarification identified by site participants in regard to the measures. A number of sites questioned the "multipart" measures and suggested that they need to be separated—again, in order to maintain stability in the measurement process, this should wait until after the next site reviews. Some of the confusion about measures can be addressed through changes to the self-assessment tool that are referenced below, but there are some minor revisions that would help clarify the intent of some measures.

- As noted above, multiple ideas have been combined into some measures. Some of these require reorganization or other minor revision.
- The specific changes to measures that are recommended are summarized in Attachment F.

C. Self Evaluation Tool

We found that many sites, once they started preparing for the site visit, used the self-assessment tool as their reference rather than the standards booklet or the key management practice matrices. This provides an opportunity to make further clarifications without adding to the booklet or the matrices. These changes could be incorporated into the next cycle of site visit preparations and, along with the minor refinements of the measures, should result in greater clarity.

- Working with the self-evaluation tool, sites sometimes lost focus on which standard the measure was addressing, which led to misconstruing the intent of the measure or a sense that there was duplication in measures. This could be improved by bolding words in each measure to provide emphasis and focus.
- Many participants suggested the development of a glossary to define some of the terms in the measures, to assure common understanding.
- With a pre-established matrix for DOH, it will be possible to provide a customized self-assessment tool to each program with only the applicable measures.
- Consider whether a program matrix for LHJs and use of the "*Sample*", "*All*" and "*Once*" concepts might clarify the process of LHJ site preparation in the future.

VII. Recommendations: Sustaining the Standards Process and Integrating the Standards into the Daily Work of the System

A. Interim Work

In addition to all the ideas referenced above, there is a need for ongoing culture and infrastructure building in regard to the standards themselves.

1. **Leadership**

Communication and Key Messages*:* The leadership of the DOH, of LHJs and Boards of Health must embrace and consistently reinforce the message of the standards—*performance and health indicator data form the foundation for establishing health policy and measuring and improving the public health system.*

- Distribute the Performance Measurement in Public Health discussion paper (Attachment D) to all DOH and LHJ leaders and discuss in management meetings to identify key messages.
- Develop and implement a communications plan for the Baseline Evaluation Results and for the ongoing standards work.
- Develop and communicate key messages for the integration of performance standards into the daily work of Washington's public health system, including addressing long-term commitment, institutional support, and the ongoing nature of the work.

Project Work Plan and Improvement Activities: A policy statement and several levels of work plans and planned improvement activities should be developed and implemented to coordinate efforts and to facilitate the integration of this work into the culture and processes of the entire system.

- Develop a model policy statement for the implementation of performance standards, to be adopted by DOH Divisions and LHJs.
- Adopt a revised matrix of standards/measures accountability for DOH programs, disseminate soon and determine where the programs that were not included in this cycle will fit in the future, so everyone knows which measures they will be accountable for in the next evaluation cycle.
- Consider development of a standards/measures accountability matrix for LHJs that spans the scope of all their program areas. This can provide the basis for further conversation about the number and type of program examples to be included in future cycles. It will also help staff see where their work connects to the Standards.
- Act on the recommended changes to the measures, and assign responsibility for development of a glossary to accompany future self-assessment.
- Convene an ongoing standards implementation team for DOH with one representative from each Division to ensure the implementation of orientation, training, and work plan activities across DOH.
- Designate one person in each LHJ to ensure the implementation of orientation, training, and work plan activities in each organization.
- Develop and implement a system level work plan driven by the PHIP and supporting the requirements of the PHIP.
- Implement a DOH work plan for oversight of the use of the baseline results and improvement work being done in the Divisions and programs across DOH, with regular timeframes for Division reporting on progress on work plan and improvement work.
- Assure LHJs have developed and implemented a work plan for use of the baseline results and improvement activities in each of the districts.
- Develop practical methods to support ongoing documentation of work related to the Standards (see recommendations regarding DOH program planning above).

2. Employee Orientation and Knowledge

Orientation Activities: It is necessary that a critical mass of managers and staff are familiar with the standards in order to integrate the philosophy and principles of standards for performance measurement into the culture of the public health system. Orientation to the standards and to the basic principles of performance measurement should be included in the DOH general orientation curriculum and in the specific DOH program and LHJ orientation processes.

- Assure that all new DOH program staff and LHJ staff are oriented to the Public Health Performance Standards.
- Assure that all current DOH and LHJ staff are oriented to the Public Health Performance Standards
- Disseminate the Standards Booklet to all DOH programs and all LHJs to assure that staff have a copy and are familiar with the standards and measures.

3. Future Training Programs

Training Resources: At the inception of the baseline training project, it was envisioned that a group of internal resource consultants would help sustain the effort during and after the baseline evaluation by providing training sessions using the videotapes and facilitating small group work and discussions. Most of the group convened in mid-June 2002 to be trained as internal resource consultants stated that they were not prepared to conduct formal training sessions for the standards project due to a general lack of knowledge about performance measurement, the public health standards, and evaluation processes. The potential time commitment for these staff was also a concern. All of the participants indicated that they were able to provide a short, basic orientation to the standards for groups of staff.

- Use the DOH Standards Implementation Team (described above) to identify internal DOH resource consultants and to facilitate their training and commitment of time to sustaining the standards work.
- Use the LHJ designated persons (described above) to identify internal LHJ resource consultants and to facilitate their training and commitment of time to sustaining the standards work.
- Provide the internal resource consultants with materials, tools, and advanced training and coaching, possibly from QA and Strategic Planning staff in the Office of the Secretary.
- Use resource consultants to deliver Basic Standards training and Preparing for Site Visit training, using the videos and materials described above (think of these as Standards 101 and 102).
- Assure that another round of Basic Standards and Preparing for the Site Visit training is provided in the months before the next cycle of site reviews. Communicate to DOH programs and LHJs that it is essential to send the person(s) who will actually be preparing the materials for the site review—in many instances, the people who actually did the work were not at the trainings and were lacking the information they needed to do the work they were assigned.

Focused Training Sessions*:* Develop and conduct further training for staff in focused areas that apply directly to their work and responsibilities (a Standards 200 series).

- Develop and conduct training sessions based on each of the Standards Topic Areas
- Develop and conduct training sessions based on each of the Key Management Practices
- Develop and conduct training sessions on Using the Self-Assessment Tool to Improve Work Processes
- Develop and conduct training sessions on Applying the *Plan-Do-Check-Act* Cycle in Your Daily Work

B. The Next Cycle Site Review Process

The single most consistent piece of feedback about the process is that the timing was terrible, coming as it did during the vacation and budget season. If the site review process were adjusted to occur in the second quarter of the calendar year, the results would be more usefully incorporated into budgets as well as causing less conflict with vacation schedules.

- The full cycle from contract to final report takes approximately 8-9 months, assuming training at the outset and 8 weeks from the distribution of the self-evaluation tool (post training) to submission of the self-evaluation tool. This timetable assumes the site schedule process utilized in 2000 and 2002: an average of four LHJ sites visited per week per surveyor, with travel time between LHJ sites during evening hours; and, DOH sites visited five days a week over several consecutive weeks. For a second quarter cycle of site reviews, a contract for the process would have to be in place no later than October or November of the preceding year.
- The implication of shifting the timing is that the next cycle would either occur in less than two years or at about 2 ¾ years from the just completed site visits. In light of the considerable effort required of the system to prepare for site visits, the longer cycle is recommended for the next time, to be followed by a more stable two-year cycle.
- In this cycle, a contract for training was issued separately from the contract for conducting the site reviews. The integration between the training and the approach to site reviews is critical, both in terms of scheduling and content. In the future, these should be combined into a single contract and schedule.

VIII. Attachment A: Cross Walk of Core Functions and Ten Essential Services to Standards

The following matrix compares the federal framework of Ten Essential Services of Public Health with the Standards for Public Health in Washington State. *Local and state health officials drafted the* Standards *with frequent reference to the Ten Essential Services, but they did not use the federal framework to organize their work. Instead, they chose to develop standards in five topic areas. For each area, they sought to assure that the Ten Essential Services were addressed. Please note the standards, as referenced here, are abbreviated. An entire standard and its measures must be read to understand its scope.*

	10 Essential Services									
Topic Area/Standard	***Assessment***			***Policy Development***		***Assurance***				
	Monitor	**Investigate**	**Inform**	**Mobilize**	**Policies**	**Enforce**	**Services**	**Workforce**	**Evaluate**	**Research**
Assessment										
1. Assessment skills and tools in place	X	X						X		
2. Information collected, analyzed, disseminated	X	X	X		X			X	X	
3. Effectiveness of programs is evaluated	X							X	X	X
4. Health policy reflect assessment information			X	X	X					
5. Confidentiality, security of data protected								X		
Communicable Disease										
1. Surveillance and reporting system maintained	X	X	X			X		X		X
2. Response plans delineate roles			X	X				X		
3. Documented investigation, control procedures		X			X	X	X	X	X	
4. Urgent messages communicated quickly			X	X			X	X		
5. Response plans routinely evaluated			X					X	X	X
Environmental Health										
1. Environmental health education planned		X	X	X				X		
2. Response prepared for environmental threats	X	X		X			X	X	X	

	10 Essential Services									
Topic Area/Standard	*Assessment*			*Policy Development*		*Assurance*				
	Monitor	**Investigate**	**Inform**	**Mobilize**	**Policies**	**Enforce**	**Services**	**Workforce**	**Evaluate**	**Research**
3. Risks and events tracked and reported	X		X	X					X	X
4. Enforcement actions taken for compliance						X		X		
Prevention/Health Promotion										
1. Policies support prevention priorities	X	X	X		X			X		X
2. Community involvement in setting priorities			X	X	X					
3. Access to prevention services			X	X			X	X	X	X
4. Prevention, early intervention provided				X	X		X	X		
5. Health promotion activities provided			X	X	X			X	X	X
Access to Critical Services										
1. Information on service availability	X		X				X			
2. Information shared on trends, over time		X	X						X	X
3. Plans developed to reduce specific gaps			X	X	X		X		X	
4. Quality and capacity monitored, reported			X			X		X	X	X

IX. Attachment B: Charts, By Standard, By Measure

LHJ Charts: 15 – 37

DOH Charts: 38 – 60

Key Management Practice Charts: 61 – 68

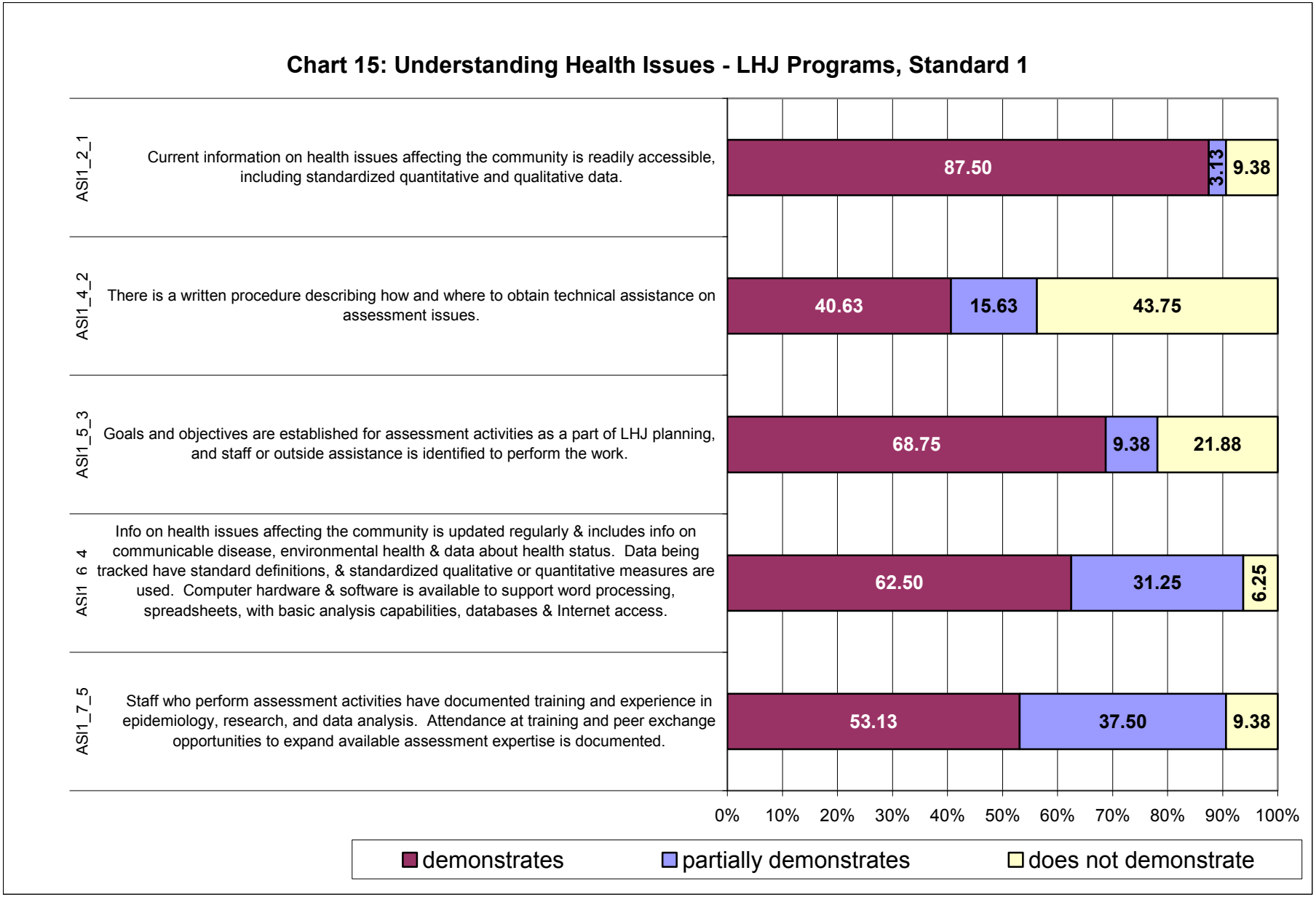


Chart 15: Understanding Health Issues - LHJ Programs, Standard 1
ASI1_2_1
Current information on health issues affecting the community is readily accessible, including standardized quantitative and qualitative data.
87.50
3.13
9.38
ASI1_4_2
There is a written procedure describing how and where to obtain technical assistance on assessment issues.
40.63
15.63
43.75
ASI1_5_3
Goals and objectives are established for assessment activities as a part of LHJ planning, and staff or outside assistance is identified to perform the work.
68.75
9.38
21.88
ASI1_6_4
Info on health issues affecting the community is updated regularly & includes info on communicable disease, environmental health & data about health status. Data being tracked have standard definitions, & standardized qualitative or quantitative measures are used. Computer hardware & software is available to support word processing, spreadsheets, with basic analysis capabilities, databases & Internet access.
62.50
31.25
6.25
ASI1_7_5
Staff who perform assessment activities have documented training and experience in epidemiology, research, and data analysis. Attendance at training and peer exchange opportunities to expand available assessment expertise is documented.
53.13
37.50
9.38
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
does not demonstrate

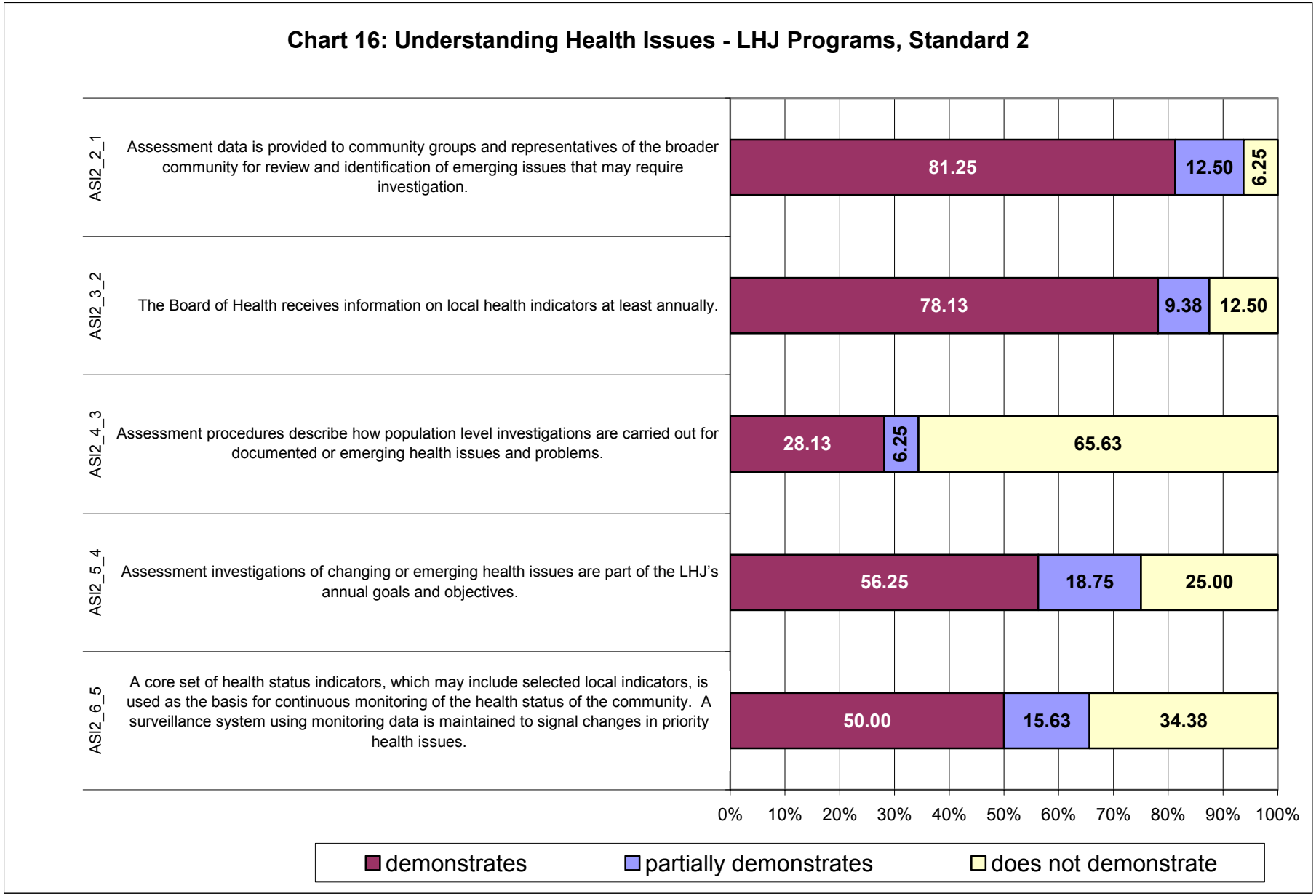


Chart 16: Understanding Health Issues - LHJ Programs, Standard 2
ASI2_2_1
Assessment data is provided to community groups and representatives of the broader community for review and identification of emerging issues that may require investigation.
81.25
12.50
6.25
ASI2_3_2
The Board of Health receives information on local health indicators at least annually.
78.13
9.38
12.50
ASI2_4_3
Assessment procedures describe how population level investigations are carried out for documented or emerging health issues and problems.
28.13
6.25
65.63
ASI2_5_4
Assessment investigations of changing or emerging health issues are part of the LHJ's annual goals and objectives.
56.25
18.75
25.00
ASI2_6_5
A core set of health status indicators, which may include selected local indicators, is used as the basis for continuous monitoring of the health status of the community. A surveillance system using monitoring data is maintained to signal changes in priority health issues.
50.00
15.63
34.38
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
does not demonstrate

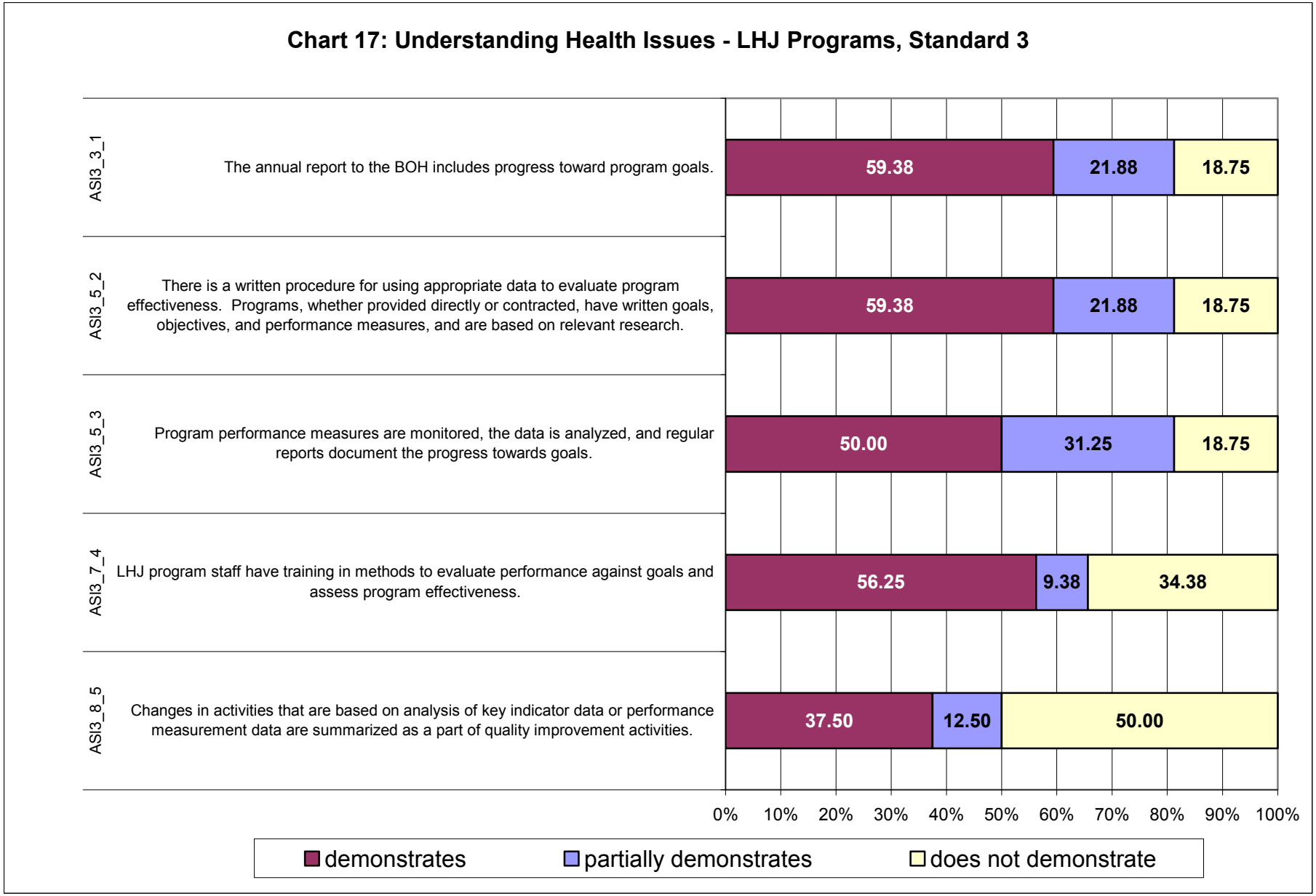


Chart 17: Understanding Health Issues - LHJ Programs, Standard 3
ASI3_3_1
The annual report to the BOH includes progress toward program goals.
59.38
21.88
18.75
ASI3_5_2
There is a written procedure for using appropriate data to evaluate program effectiveness. Programs, whether provided directly or contracted, have written goals, objectives, and performance measures, and are based on relevant research.
59.38
21.88
18.75
ASI3_5_3
Program performance measures are monitored, the data is analyzed, and regular reports document the progress towards goals.
50.00
31.25
18.75
ASI3_7_4
LHJ program staff have training in methods to evaluate performance against goals and assess program effectiveness.
56.25
9.38
34.38
ASI3_8_5
Changes in activities that are based on analysis of key indicator data or performance measurement data are summarized as a part of quality improvement activities.
37.50
12.50
50.00
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
does not demonstrate

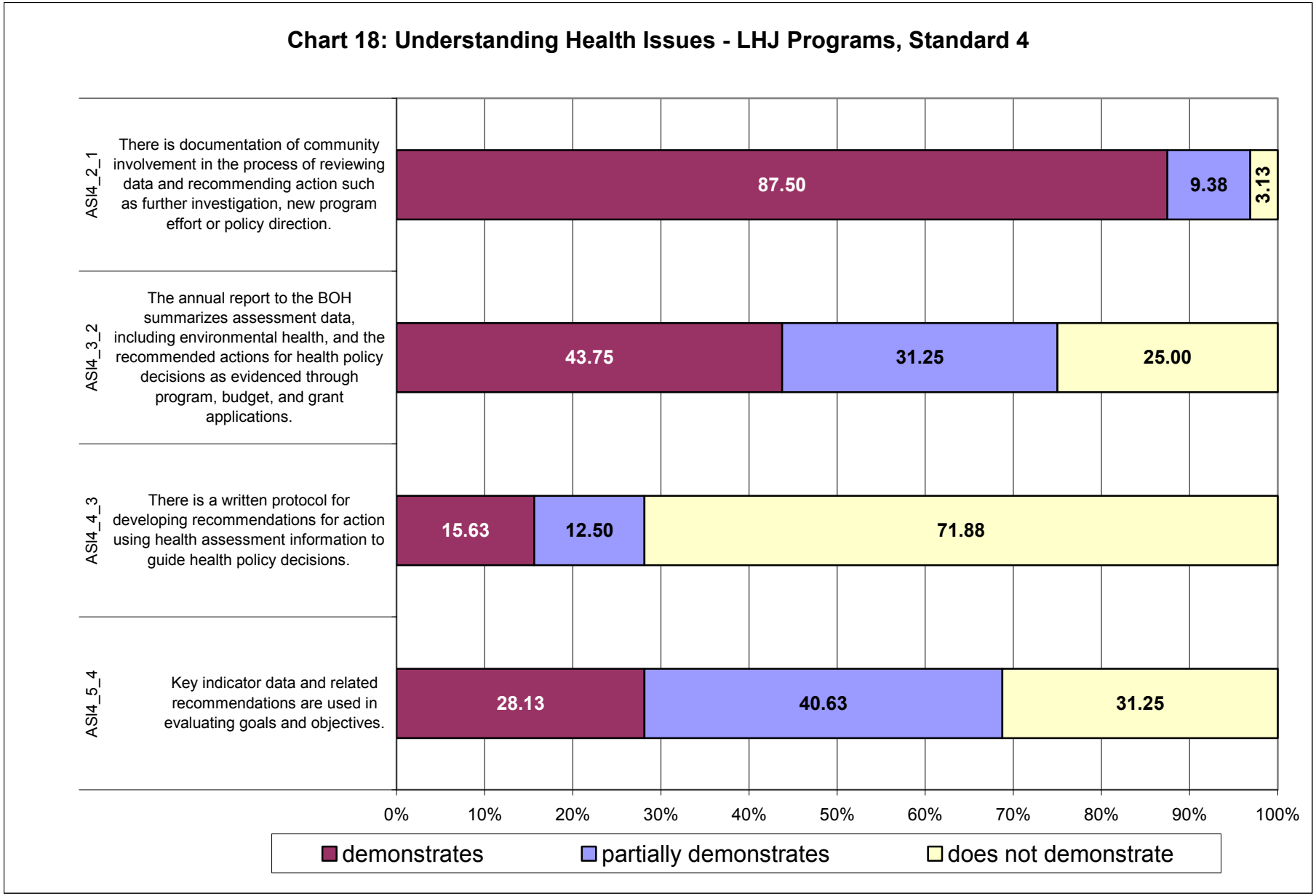


Chart 18: Understanding Health Issues - LHJ Programs, Standard 4
ASI4_2_1
There is documentation of community involvement in the process of reviewing data and recommending action such as further investigation, new program effort or policy direction.
87.50
9.38
3.13
ASI4_3_2
The annual report to the BOH summarizes assessment data, including environmental health, and the recommended actions for health policy decisions as evidenced through program, budget, and grant applications.
43.75
31.25
25.00
ASI4_4_3
There is a written protocol for developing recommendations for action using health assessment information to guide health policy decisions.
15.63
12.50
71.88
ASI4_5_4
Key indicator data and related recommendations are used in evaluating goals and objectives.
28.13
40.63
31.25
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
does not demonstrate

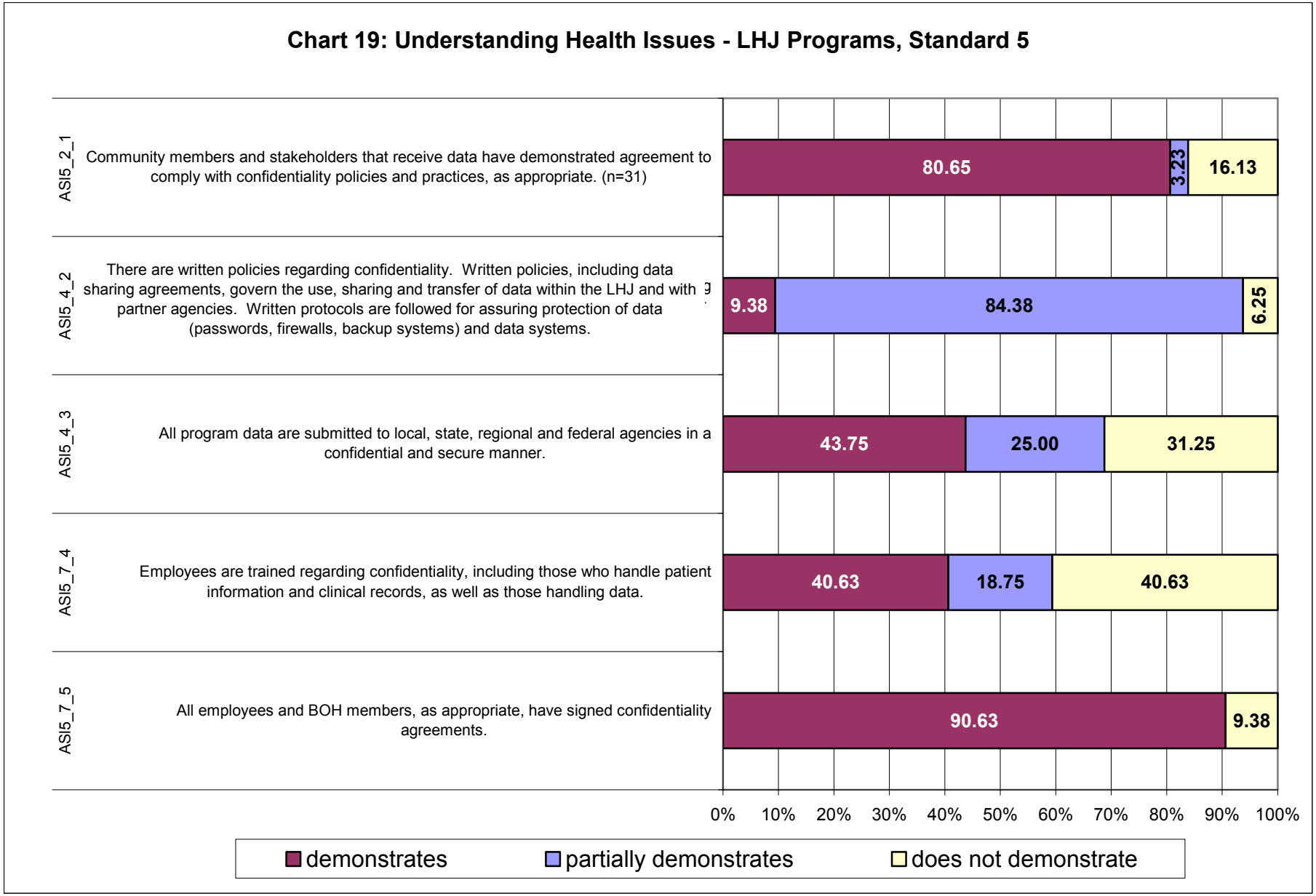


Chart 19: Understanding Health Issues - LHJ Programs, Standard 5
ASI5_2_1
Community members and stakeholders that receive data have demonstrated agreement to comply with confidentiality policies and practices, as appropriate. (n=31)
80.65
3.23
16.13
ASI5_4_2
There are written policies regarding confidentiality. Written policies, including data sharing agreements, govern the use, sharing and transfer of data within the LHJ and with partner agencies. Written protocols are followed for assuring protection of data (passwords, firewalls, backup systems) and data systems.
9.38
84.38
6.25
ASI5_4_3
All program data are submitted to local, state, regional and federal agencies in a confidential and secure manner.
43.75
25.00
31.25
ASI5_7_4
Employees are trained regarding confidentiality, including those who handle patient information and clinical records, as well as those handling data.
40.63
18.75
40.63
ASI5_7_5
All employees and BOH members, as appropriate, have signed confidentiality agreements.
90.63
9.38
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
does not demonstrate

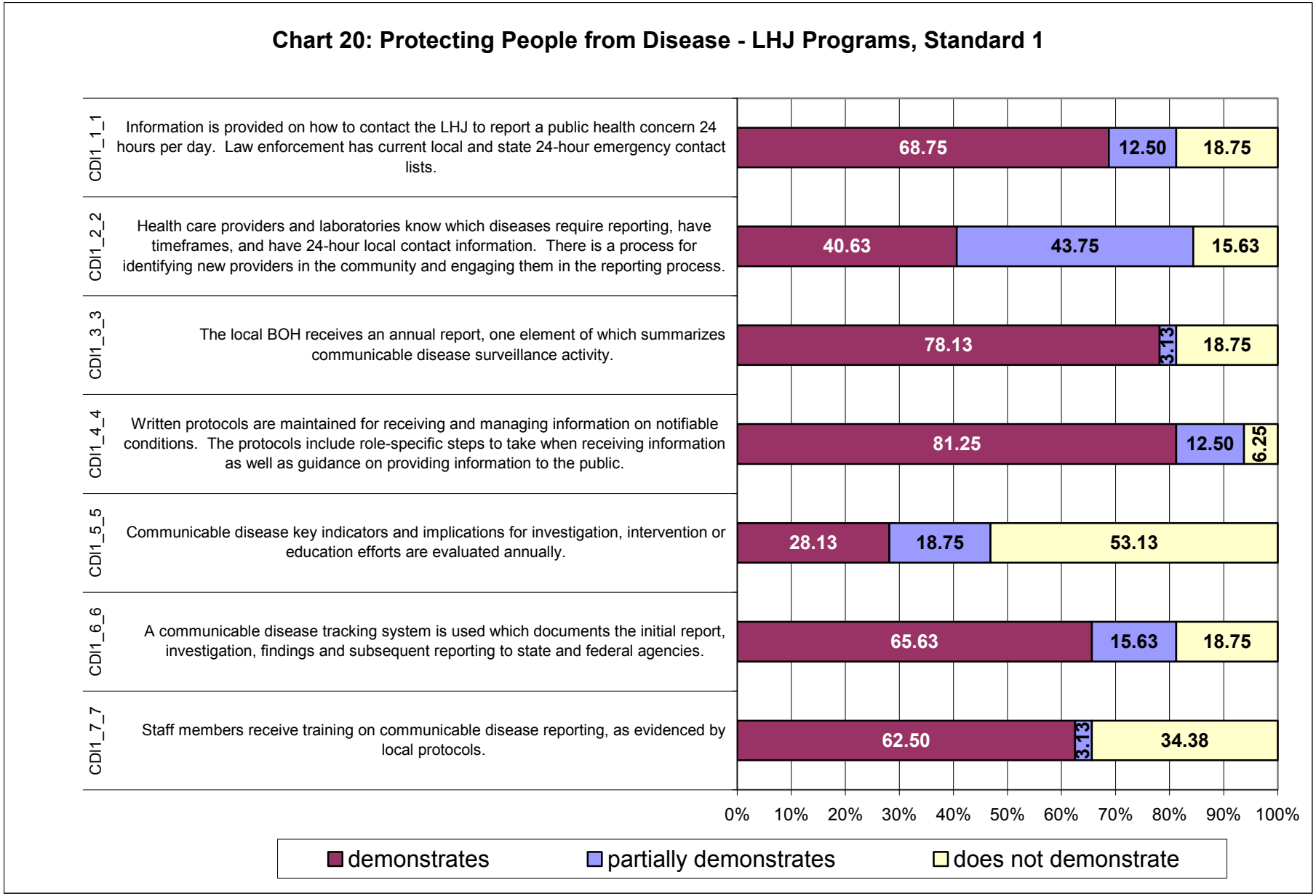


Chart 20: Protecting People from Disease - LHJ Programs, Standard 1
CDI1_1_1
Information is provided on how to contact the LHJ to report a public health concern 24 hours per day. Law enforcement has current local and state 24-hour emergency contact lists.
68.75
12.50
18.75
CDI1_2_2
Health care providers and laboratories know which diseases require reporting, have timeframes, and have 24-hour local contact information. There is a process for identifying new providers in the community and engaging them in the reporting process.
40.63
43.75
15.63
CDI1_3_3
The local BOH receives an annual report, one element of which summarizes communicable disease surveillance activity.
78.13
3.13
18.75
CDI1_4_4
Written protocols are maintained for receiving and managing information on notifiable conditions. The protocols include role-specific steps to take when receiving information as well as guidance on providing information to the public.
81.25
12.50
6.25
CDI1_5_5
Communicable disease key indicators and implications for investigation, intervention or education efforts are evaluated annually.
28.13
18.75
53.13
CDI1_6_6
A communicable disease tracking system is used which documents the initial report, investigation, findings and subsequent reporting to state and federal agencies.
65.63
15.63
18.75
CDI1_7_7
Staff members receive training on communicable disease reporting, as evidenced by local protocols.
62.50
3.13
34.38
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
does not demonstrate

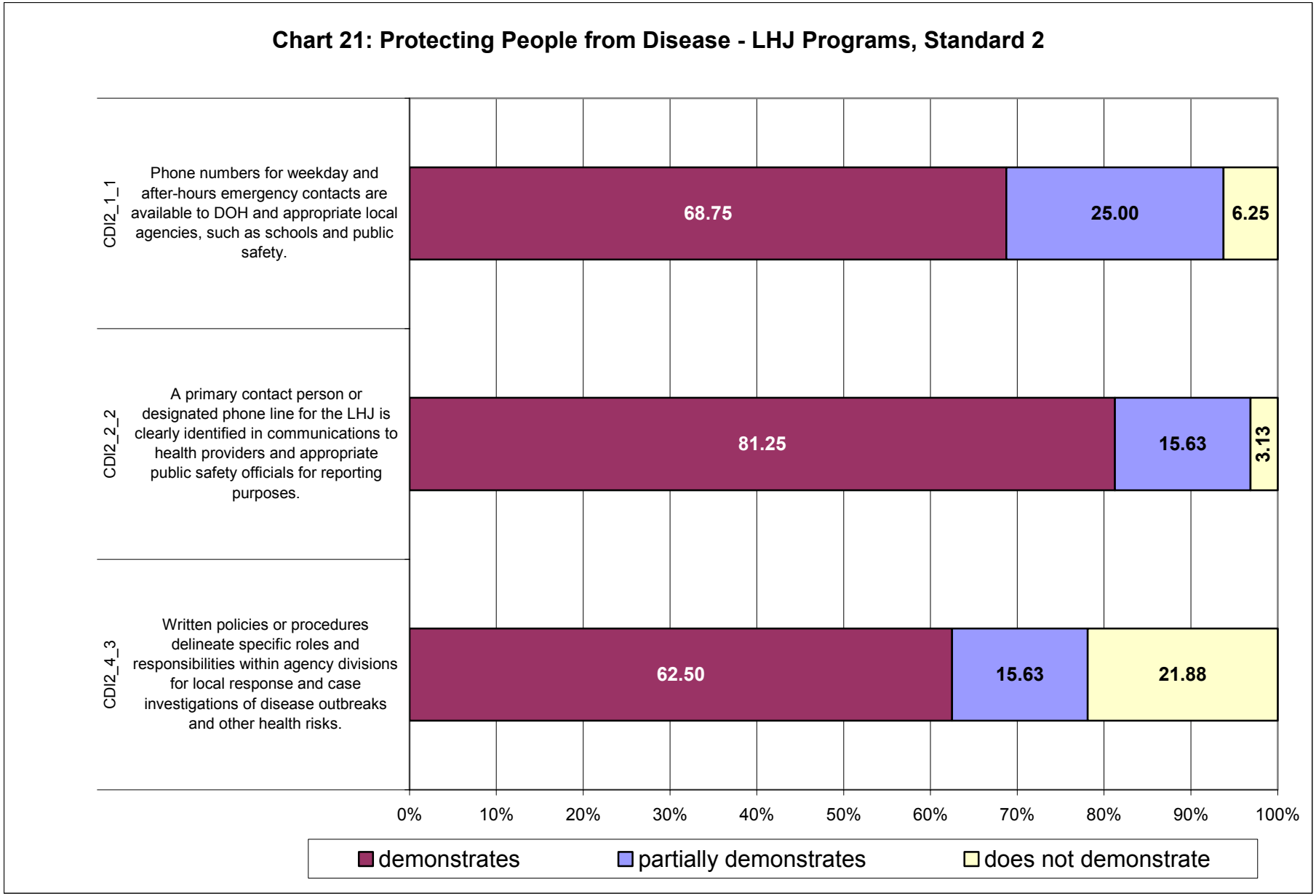


Chart 21: Protecting People from Disease - LHJ Programs, Standard 2
CDI2_1_1
Phone numbers for weekday and after-hours emergency contacts are available to DOH and appropriate local agencies, such as schools and public safety.
68.75
25.00
6.25
CDI2_2_2
A primary contact person or designated phone line for the LHJ is clearly identified in communications to health providers and appropriate public safety officials for reporting purposes.
81.25
15.63
3.13
CDI2_4_3
Written policies or procedures delineate specific roles and responsibilities within agency divisions for local response and case investigations of disease outbreaks and other health risks.
62.50
15.63
21.88
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
does not demonstrate

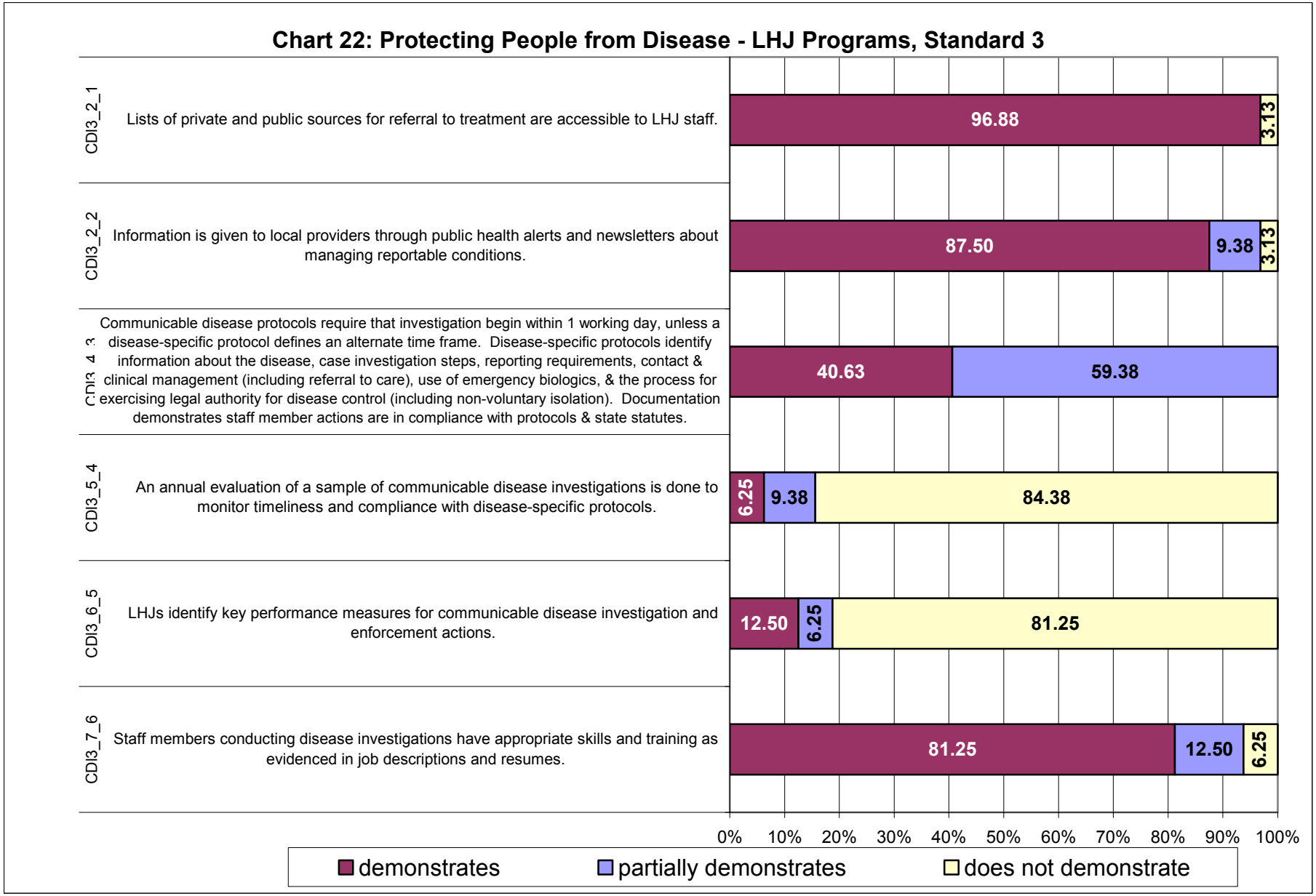


Chart 22: Protecting People from Disease - LHJ Programs, Standard 3
CDI3_2_1
Lists of private and public sources for referral to treatment are accessible to LHJ staff.
96.88
3.13
CDI3_2_2
Information is given to local providers through public health alerts and newsletters about managing reportable conditions.
87.50
9.38
3.13
CDI3_4_3
Communicable disease protocols require that investigation begin within 1 working day, unless a disease-specific protocol defines an alternate time frame. Disease-specific protocols identify information about the disease, case investigation steps, reporting requirements, contact & clinical management (including referral to care), use of emergency biologics, & the process for exercising legal authority for disease control (including non-voluntary isolation). Documentation demonstrates staff member actions are in compliance with protocols & state statutes.
40.63
59.38
CDI3_5_4
An annual evaluation of a sample of communicable disease investigations is done to monitor timeliness and compliance with disease-specific protocols.
6.25
9.38
84.38
CDI3_6_5
LHJs identify key performance measures for communicable disease investigation and enforcement actions.
12.50
6.25
81.25
CDI3_7_6
Staff members conducting disease investigations have appropriate skills and training as evidenced in job descriptions and resumes.
81.25
12.50
6.25
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
does not demonstrate

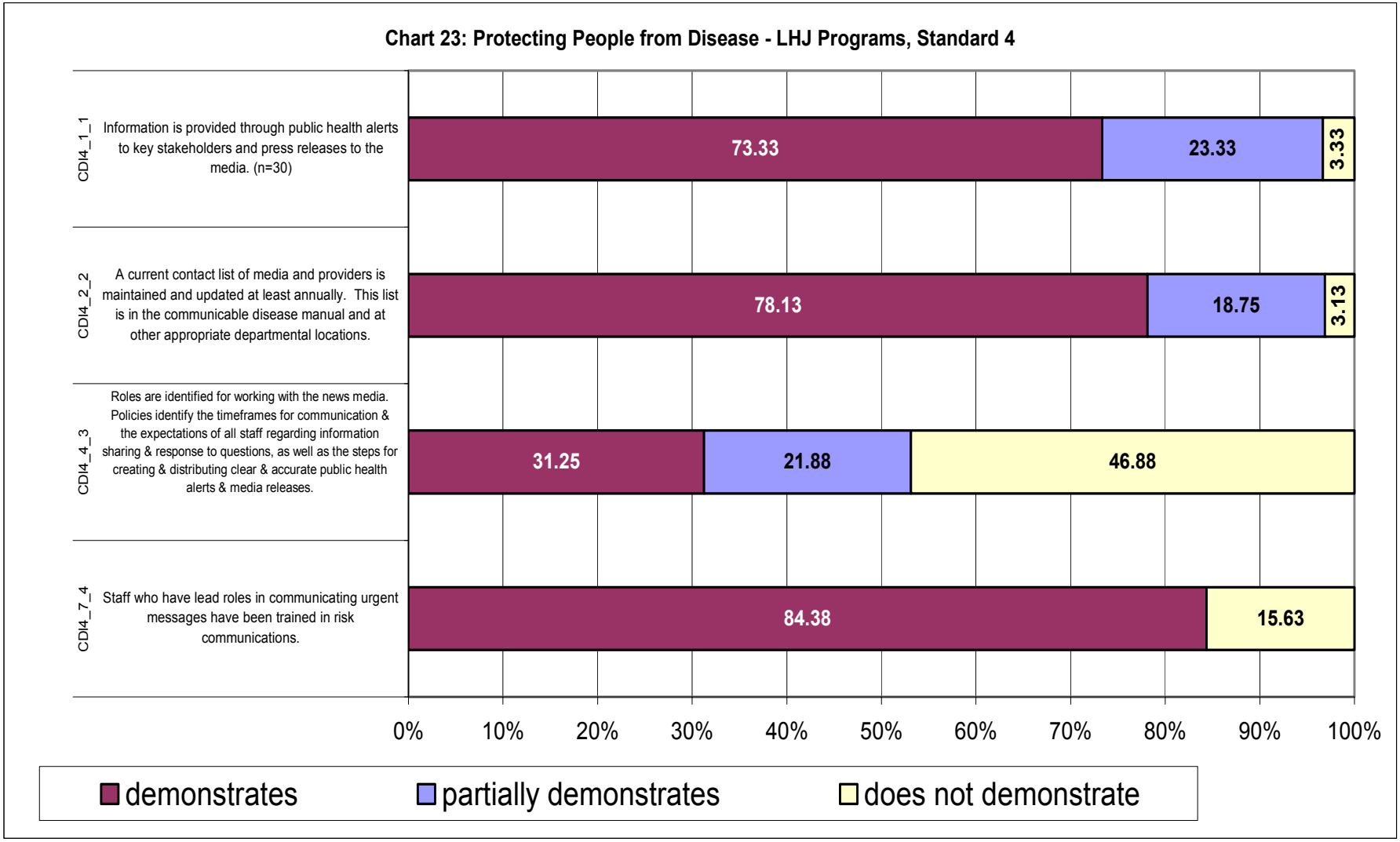


Chart 23: Protecting People from Disease - LHJ Programs, Standard 4
CDI4_1_1
Information is provided through public health alerts to key stakeholders and press releases to the media. (n=30)
73.33
23.33
3.33
CDI4_2_2
A current contact list of media and providers is maintained and updated at least annually. This list is in the communicable disease manual and at other appropriate departmental locations.
78.13
18.75
3.13
CDI4_4_3
Roles are identified for working with the news media. Policies identify the timeframes for communication & the expectations of all staff regarding information sharing & response to questions, as well as the steps for creating & distributing clear & accurate public health alerts & media releases.
31.25
21.88
46.88
CDI4_7_4
Staff who have lead roles in communicating urgent messages have been trained in risk communications.
84.38
15.63
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
does not demonstrate

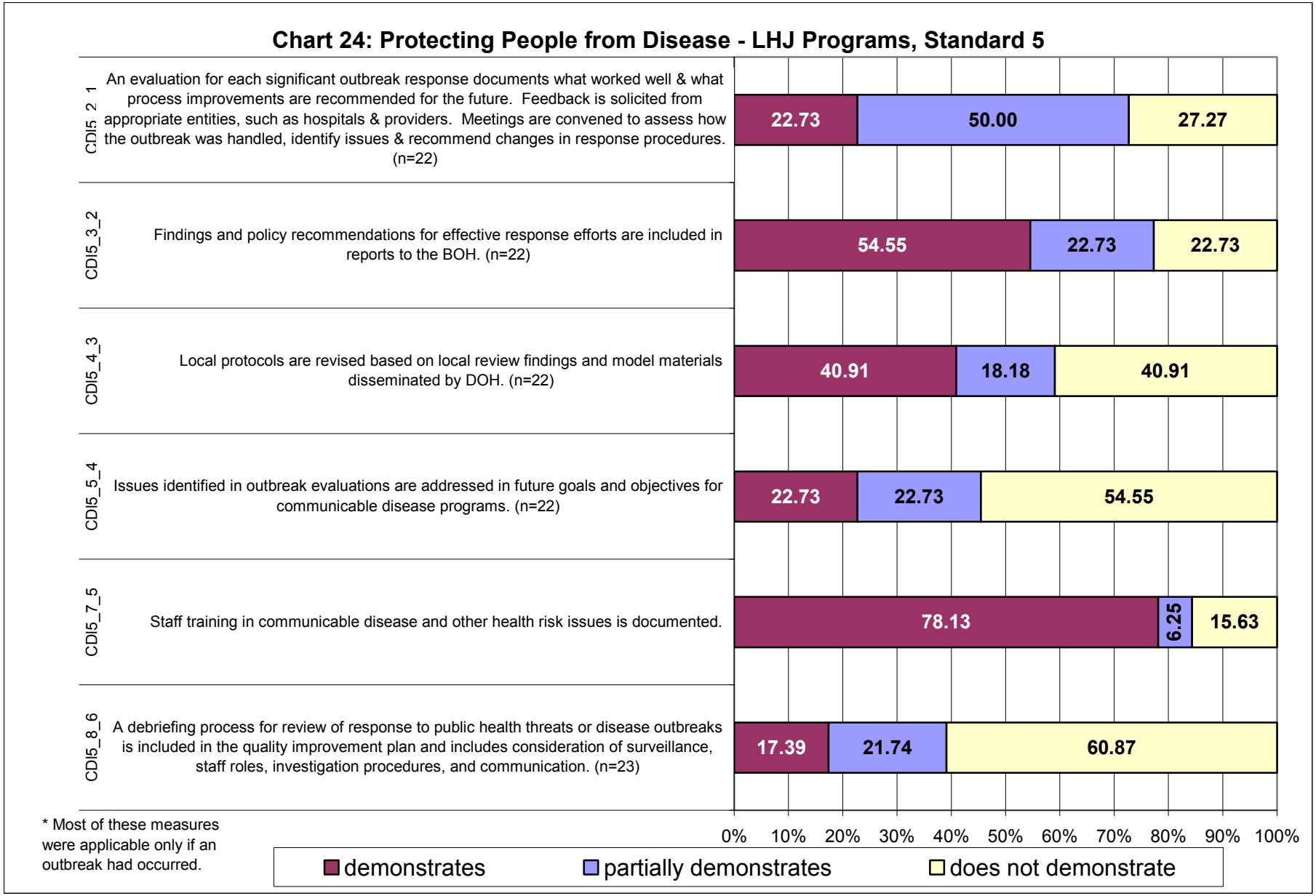


Chart 24: Protecting People from Disease - LHJ Programs, Standard 5
CDI5_2_1
An evaluation for each significant outbreak response documents what worked well & what process improvements are recommended for the future. Feedback is solicited from appropriate entities, such as hospitals & providers. Meetings are convened to assess how the outbreak was handled, identify issues & recommend changes in response procedures. (n=22)
22.73
50.00
27.27
CDI5_3_2
Findings and policy recommendations for effective response efforts are included in reports to the BOH. (n=22)
54.55
22.73
22.73
CDI5_4_3
Local protocols are revised based on local review findings and model materials disseminated by DOH. (n=22)
40.91
18.18
40.91
CDI5_5_4
Issues identified in outbreak evaluations are addressed in future goals and objectives for communicable disease programs. (n=22)
22.73
22.73
54.55
CDI5_7_5
Staff training in communicable disease and other health risk issues is documented.
78.13
6.25
15.63
CDI5_8_6
A debriefing process for review of response to public health threats or disease outbreaks is included in the quality improvement plan and includes consideration of surveillance, staff roles, investigation procedures, and communication. (n=23)
17.39
21.74
60.87
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
* Most of these measures were applicable only if an outbreak had occurred.
demonstrates
partially demonstrates
does not demonstrate

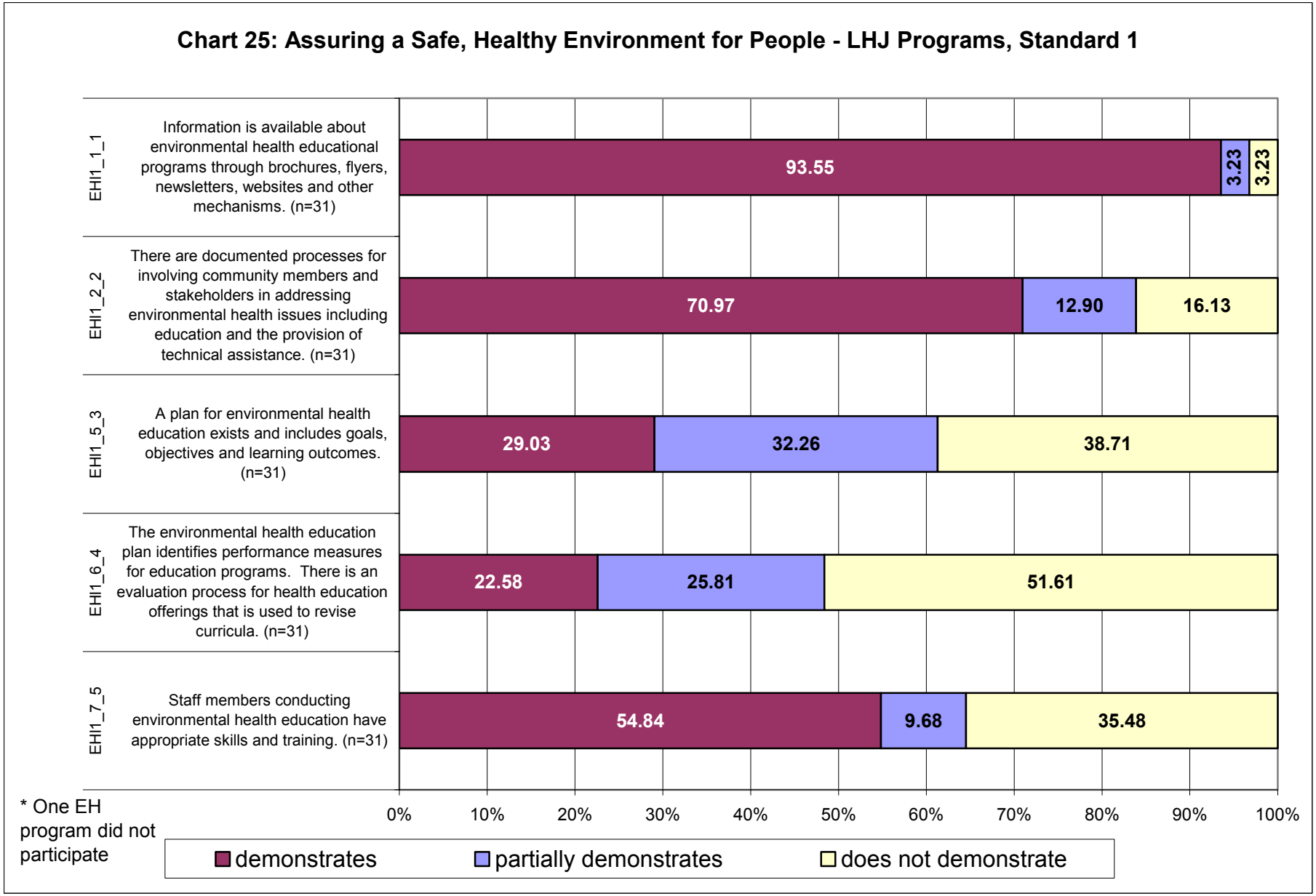


Chart 25: Assuring a Safe, Healthy Environment for People - LHJ Programs, Standard 1
EHI1_1_1
Information is available about environmental health educational programs through brochures, flyers, newsletters, websites and other mechanisms. (n=31)
93.55
3.23
3.23
EHI1_2_2
There are documented processes for involving community members and stakeholders in addressing environmental health issues including education and the provision of technical assistance. (n=31)
70.97
12.90
16.13
EHI1_5_3
A plan for environmental health education exists and includes goals, objectives and learning outcomes. (n=31)
29.03
32.26
38.71
EHI1_6_4
The environmental health education plan identifies performance measures for education programs. There is an evaluation process for health education offerings that is used to revise curricula. (n=31)
22.58
25.81
51.61
EHI1_7_5
Staff members conducting environmental health education have appropriate skills and training. (n=31)
54.84
9.68
35.48
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
* One EH program did not participate
demonstrates
partially demonstrates
does not demonstrate

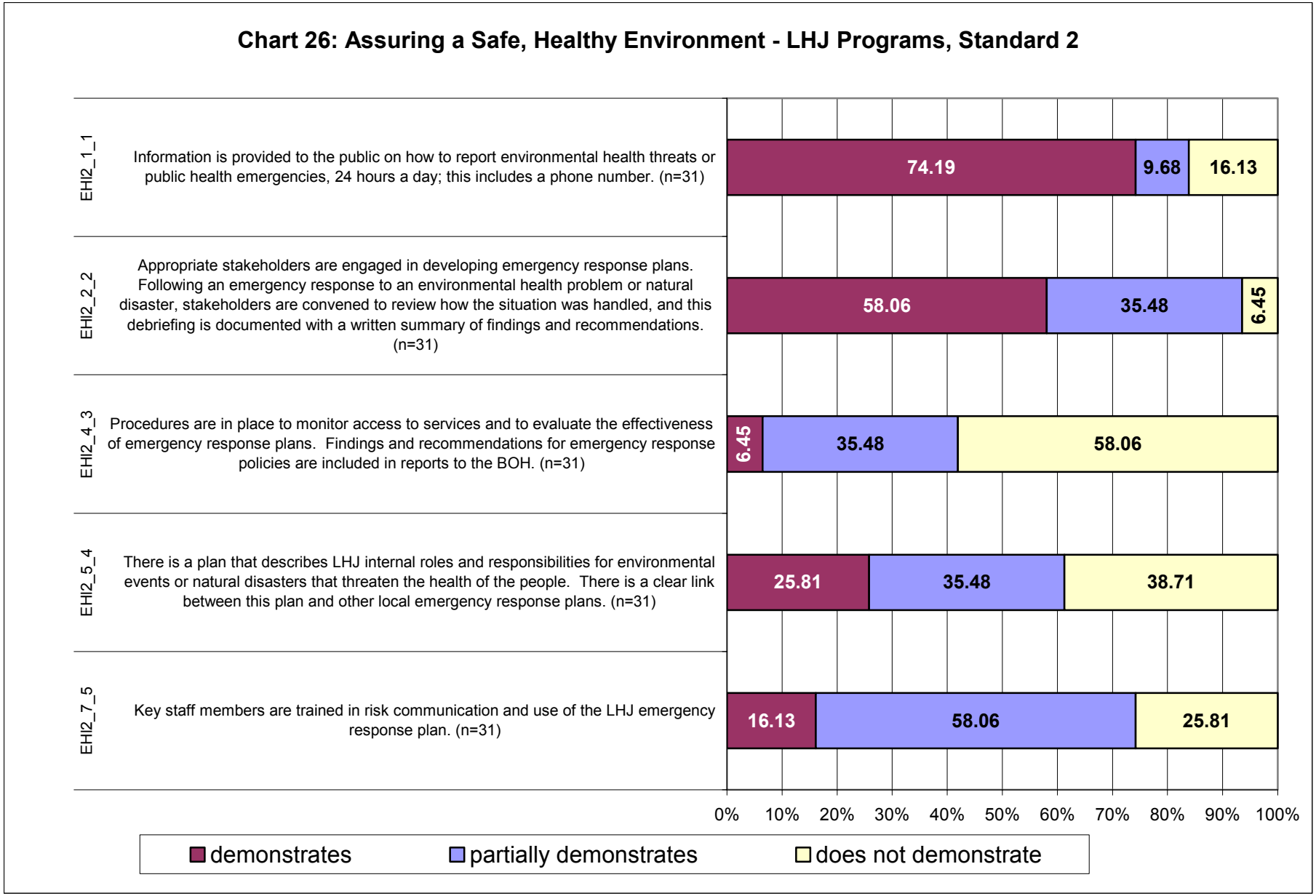


Chart 26: Assuring a Safe, Healthy Environment - LHJ Programs, Standard 2
EHI2_1_1
Information is provided to the public on how to report environmental health threats or public health emergencies, 24 hours a day; this includes a phone number. (n=31)
74.19
9.68
16.13
EHI2_2_2
Appropriate stakeholders are engaged in developing emergency response plans. Following an emergency response to an environmental health problem or natural disaster, stakeholders are convened to review how the situation was handled, and this debriefing is documented with a written summary of findings and recommendations. (n=31)
58.06
35.48
6.45
EHI2_4_3
Procedures are in place to monitor access to services and to evaluate the effectiveness of emergency response plans. Findings and recommendations for emergency response policies are included in reports to the BOH. (n=31)
6.45
35.48
58.06
EHI2_5_4
There is a plan that describes LHJ internal roles and responsibilities for environmental events or natural disasters that threaten the health of the people. There is a clear link between this plan and other local emergency response plans. (n=31)
25.81
35.48
38.71
EHI2_7_5
Key staff members are trained in risk communication and use of the LHJ emergency response plan. (n=31)
16.13
58.06
25.81
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
does not demonstrate

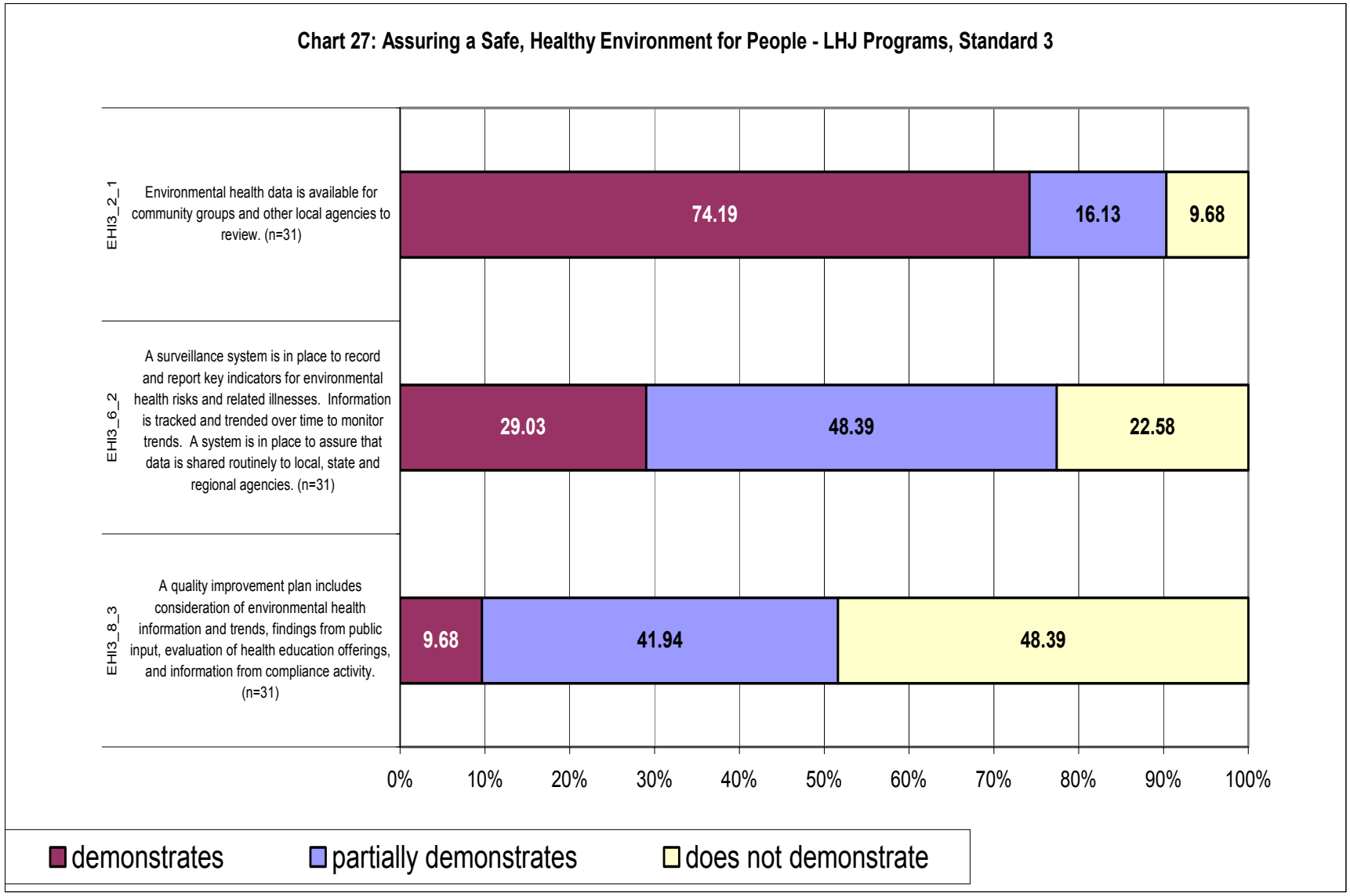


Chart 27: Assuring a Safe, Healthy Environment for People - LHJ Programs, Standard 3
EHI3_2_1
Environmental health data is available for community groups and other local agencies to review. (n=31)
74.19
16.13
9.68
EHI3_6_2
A surveillance system is in place to record and report key indicators for environmental health risks and related illnesses. Information is tracked and trended over time to monitor trends. A system is in place to assure that data is shared routinely to local, state and regional agencies. (n=31)
29.03
48.39
22.58
EHI3_8_3
A quality improvement plan includes consideration of environmental health information and trends, findings from public input, evaluation of health education offerings, and information from compliance activity. (n=31)
9.68
41.94
48.39
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
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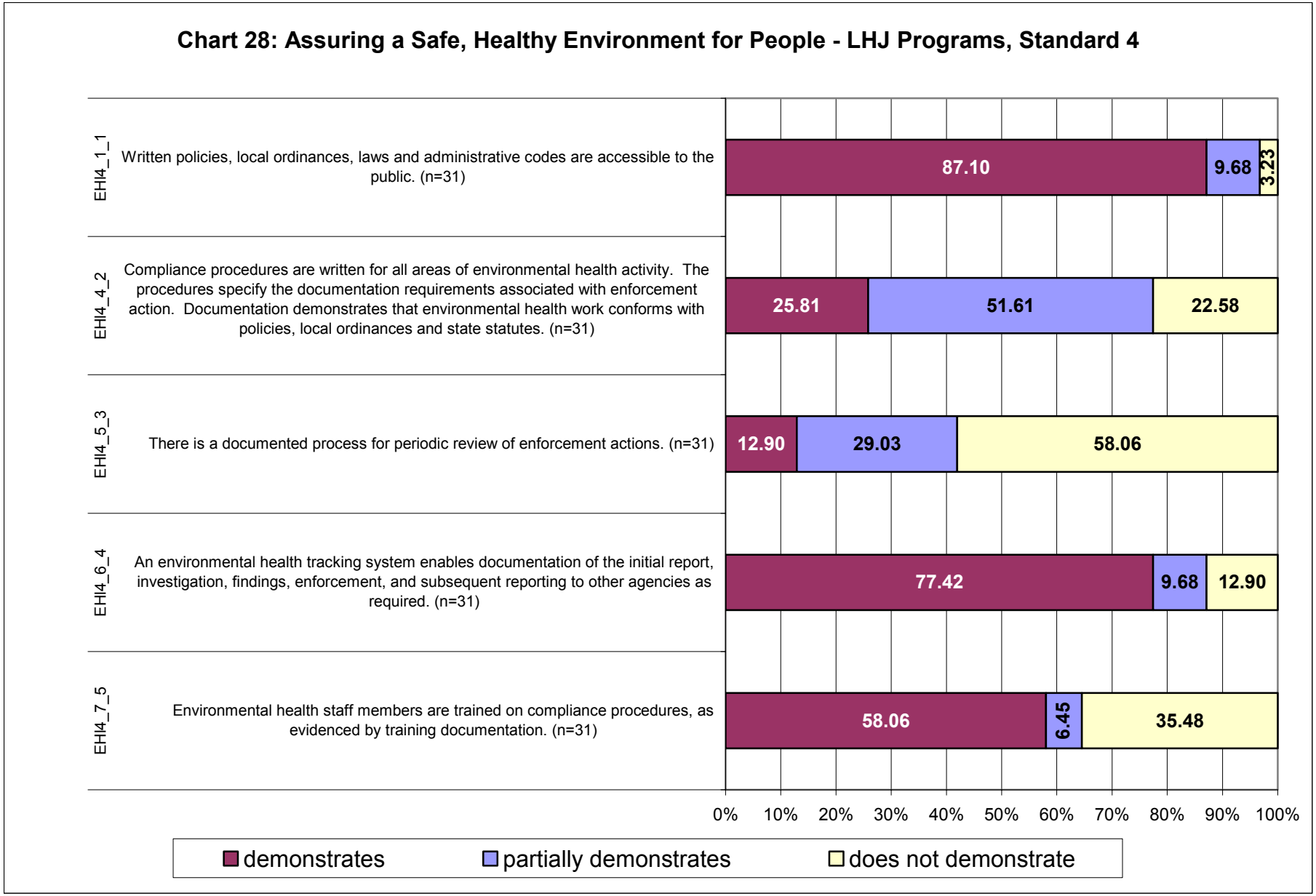
Chart 28: Assuring a Safe, Healthy Environment for People - LHJ Programs, Standard 4
EHI4_1_1
Written policies, local ordinances, laws and administrative codes are accessible to the public. (n=31)
87.10
9.68
3.23
EHI4_4_2
Compliance procedures are written for all areas of environmental health activity. The procedures specify the documentation requirements associated with enforcement action. Documentation demonstrates that environmental health work conforms with policies, local ordinances and state statutes. (n=31)
25.81
51.61
22.58
EHI4_5_3
There is a documented process for periodic review of enforcement actions. (n=31)
12.90
29.03
58.06
EHI4_6_4
An environmental health tracking system enables documentation of the initial report, investigation, findings, enforcement, and subsequent reporting to other agencies as required. (n=31)
77.42
9.68
12.90
EHI4_7_5
Environmental health staff members are trained on compliance procedures, as evidenced by training documentation. (n=31)
58.06
6.45
35.48
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
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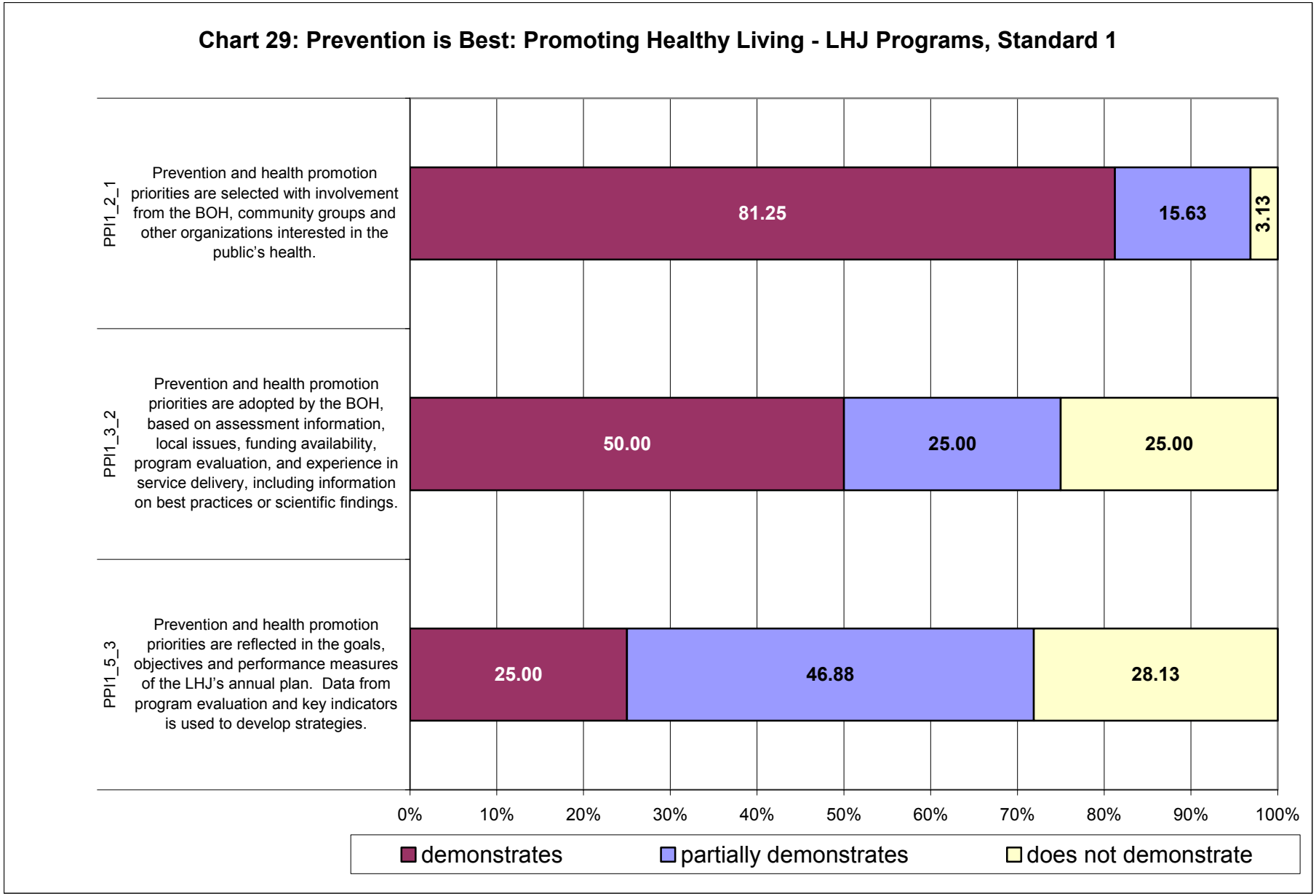
Chart 29: Prevention is Best: Promoting Healthy Living - LHJ Programs, Standard 1
PPI1_2_1
Prevention and health promotion priorities are selected with involvement from the BOH, community groups and other organizations interested in the public's health.
81.25
15.63
3.13
PPI1_3_2
Prevention and health promotion priorities are adopted by the BOH, based on assessment information, local issues, funding availability, program evaluation, and experience in service delivery, including information on best practices or scientific findings.
50.00
25.00
25.00
PPI1_5_3
Prevention and health promotion priorities are reflected in the goals, objectives and performance measures of the LHJ's annual plan. Data from program evaluation and key indicators is used to develop strategies.
25.00
46.88
28.13
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
does not demonstrate

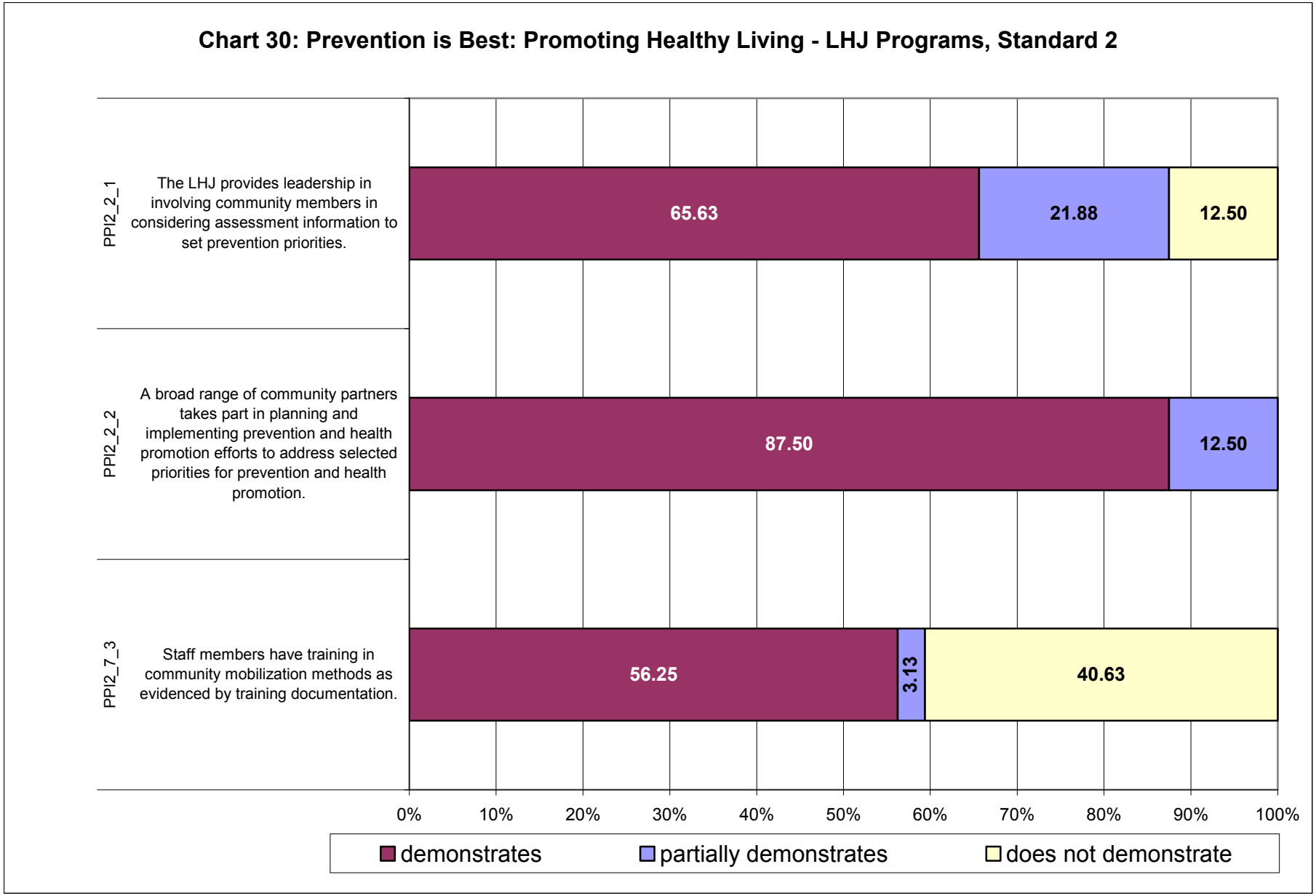
Chart 30: Prevention is Best: Promoting Healthy Living - LHJ Programs, Standard 2
PPI2_2_1
The LHJ provides leadership in involving community members in considering assessment information to set prevention priorities.
65.63
21.88
12.50
PPI2_2_2
A broad range of community partners takes part in planning and implementing prevention and health promotion efforts to address selected priorities for prevention and health promotion.
87.50
12.50
PPI2_7_3
Staff members have training in community mobilization methods as evidenced by training documentation.
56.25
3.13
40.63
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
does not demonstrate

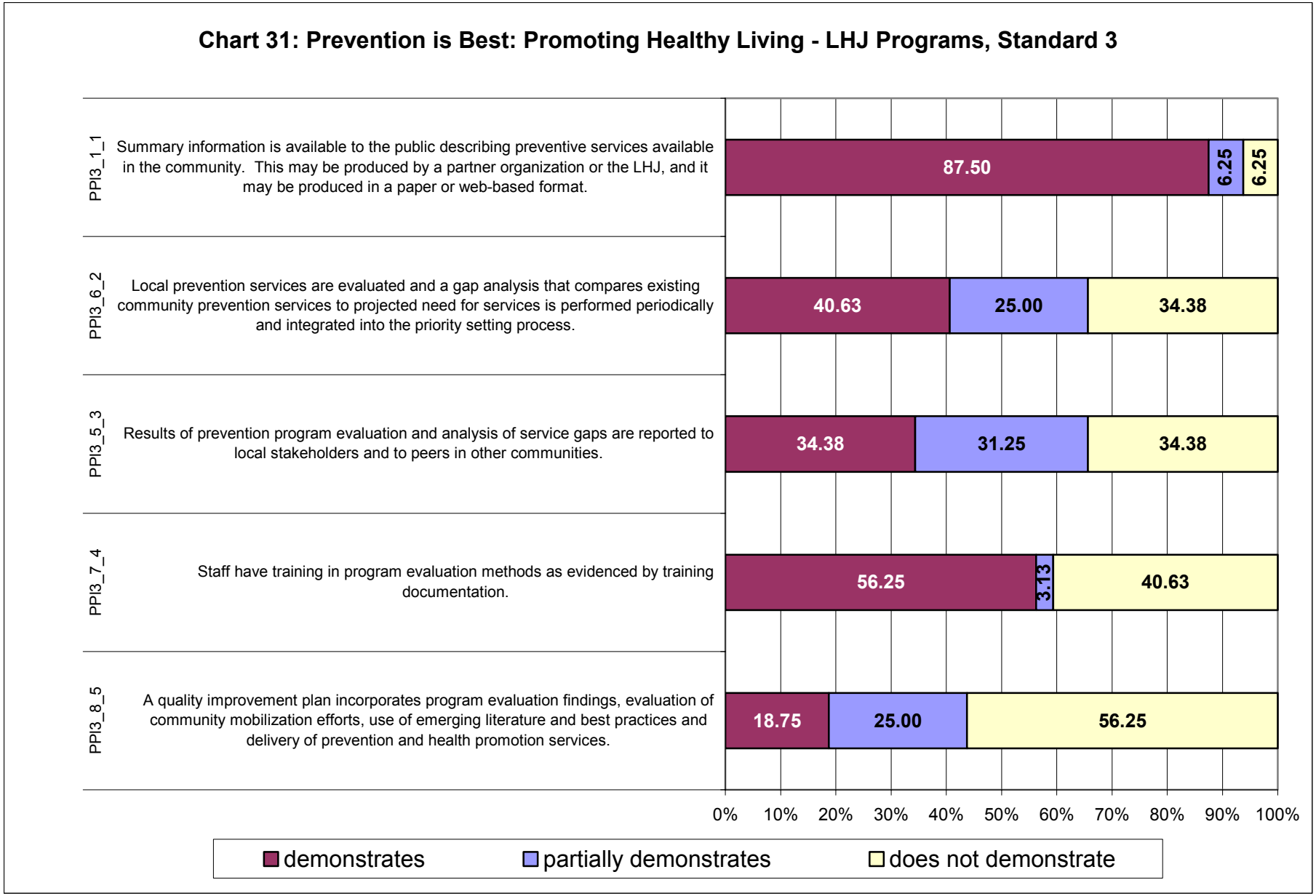
Chart 31: Prevention is Best: Promoting Healthy Living - LHJ Programs, Standard 3
PPI3_1_1
Summary information is available to the public describing preventive services available in the community. This may be produced by a partner organization or the LHJ, and it may be produced in a paper or web-based format.
87.50
6.25
6.25
PPI3_6_2
Local prevention services are evaluated and a gap analysis that compares existing community prevention services to projected need for services is performed periodically and integrated into the priority setting process.
40.63
25.00
34.38
PPI3_5_3
Results of prevention program evaluation and analysis of service gaps are reported to local stakeholders and to peers in other communities.
34.38
31.25
34.38
PPI3_7_4
Staff have training in program evaluation methods as evidenced by training documentation.
56.25
3.13
40.63
PPI3_8_5
A quality improvement plan incorporates program evaluation findings, evaluation of community mobilization efforts, use of emerging literature and best practices and delivery of prevention and health promotion services.
18.75
25.00
56.25
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
does not demonstrate

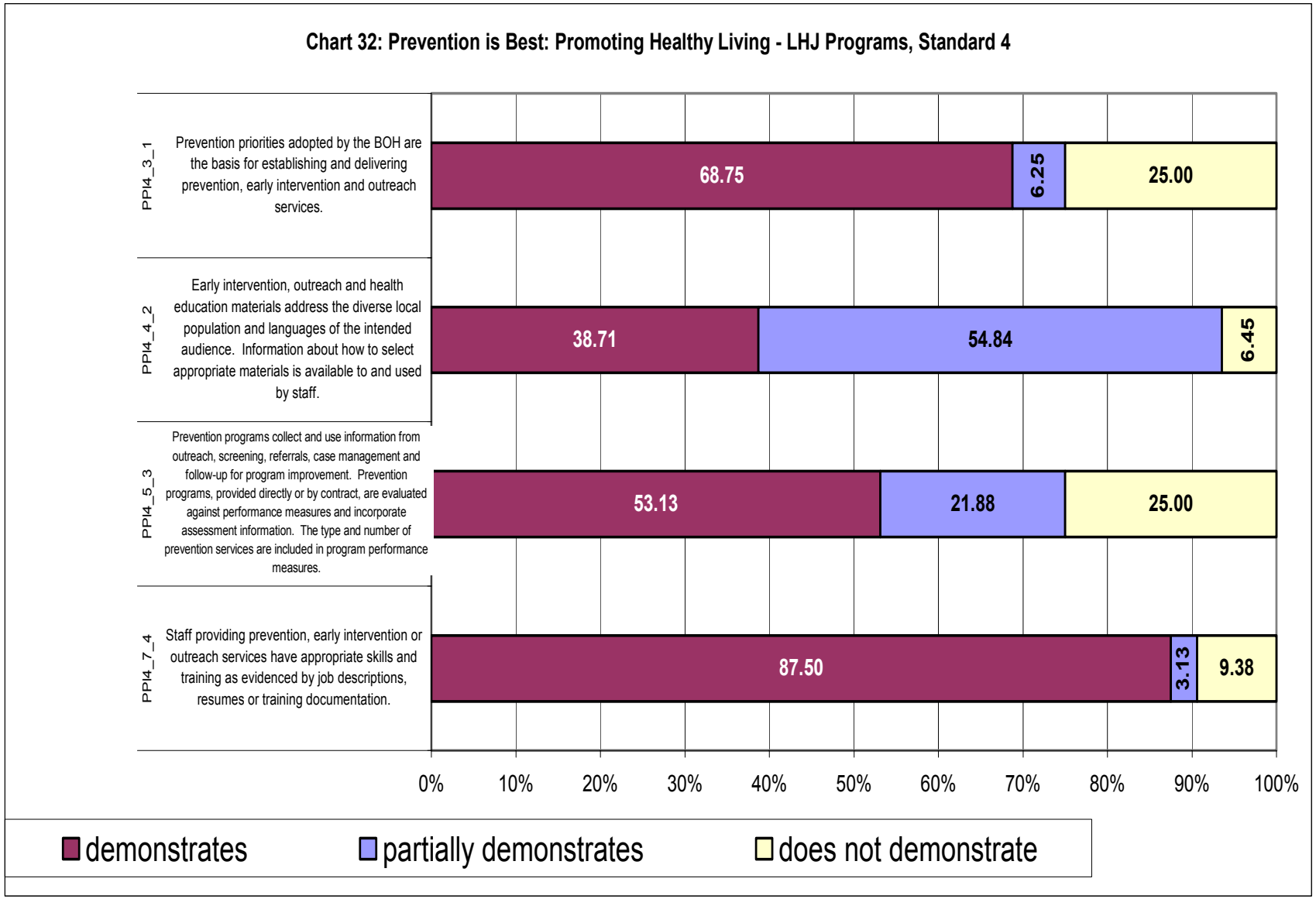
Chart 32: Prevention is Best: Promoting Healthy Living - LHJ Programs, Standard 4
PPI4_3_1
Prevention priorities adopted by the BOH are the basis for establishing and delivering prevention, early intervention and outreach services.
68.75
6.25
25.00
PPI4_4_2
Early intervention, outreach and health education materials address the diverse local population and languages of the intended audience. Information about how to select appropriate materials is available to and used by staff.
38.71
54.84
6.45
PPI4_5_3
Prevention programs collect and use information from outreach, screening, referrals, case management and follow-up for program improvement. Prevention programs, provided directly or by contract, are evaluated against performance measures and incorporate assessment information. The type and number of prevention services are included in program performance measures.
53.13
21.88
25.00
PPI4_7_4
Staff providing prevention, early intervention or outreach services have appropriate skills and training as evidenced by job descriptions, resumes or training documentation.
87.50
3.13
9.38
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
does not demonstrate

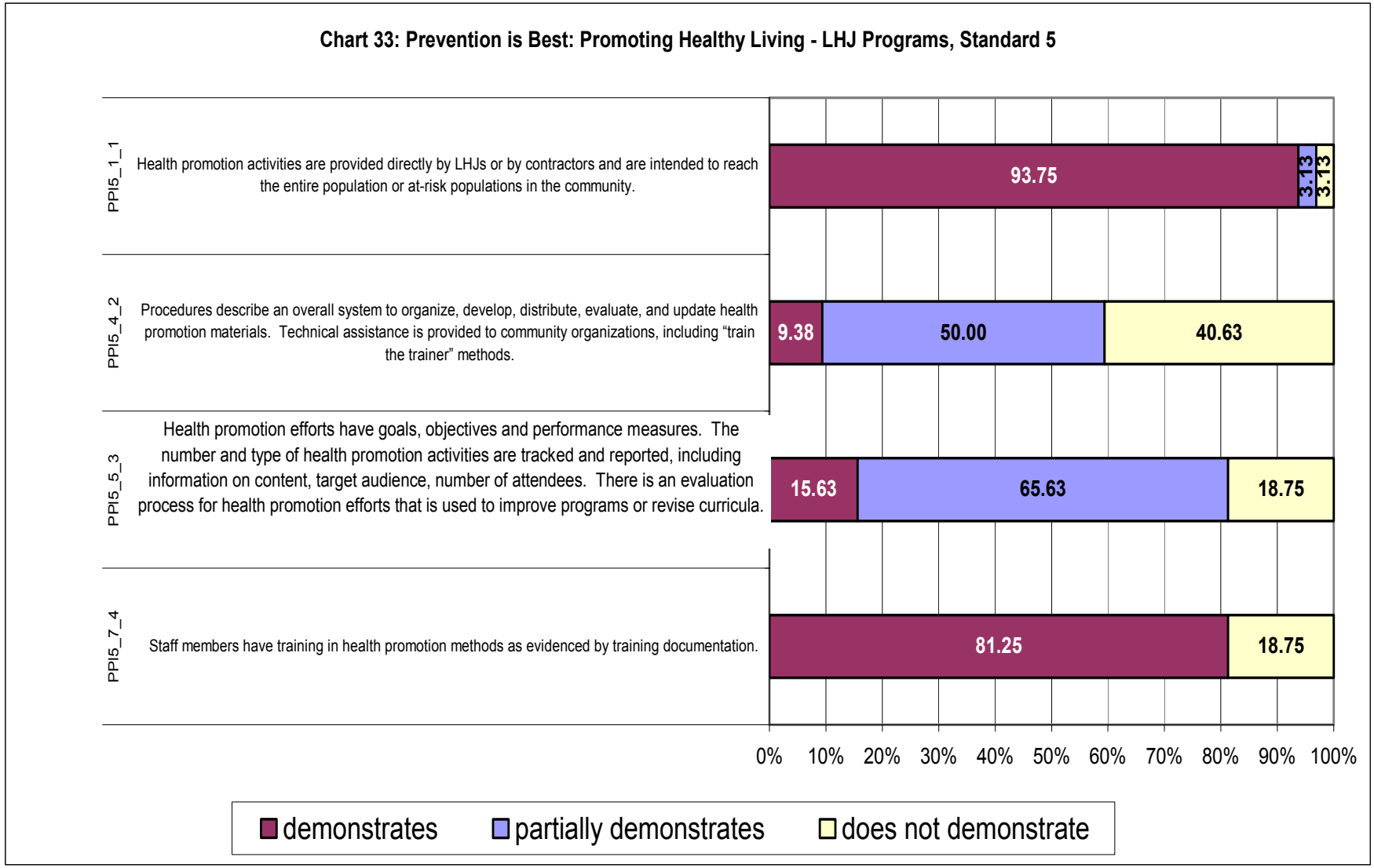
Chart 33: Prevention is Best: Promoting Healthy Living - LHJ Programs, Standard 5
PPI5_1_1
Health promotion activities are provided directly by LHJs or by contractors and are intended to reach the entire population or at-risk populations in the community.
93.75
3.13
3.13
PPI5_4_2
Procedures describe an overall system to organize, develop, distribute, evaluate, and update health promotion materials. Technical assistance is provided to community organizations, including "train the trainer" methods.
9.38
50.00
40.63
PPI5_5_3
Health promotion efforts have goals, objectives and performance measures. The number and type of health promotion activities are tracked and reported, including information on content, target audience, number of attendees. There is an evaluation process for health promotion efforts that is used to improve programs or revise curricula.
15.63
65.63
18.75
PPI5_7_4
Staff members have training in health promotion methods as evidenced by training documentation.
81.25
18.75
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
does not demonstrate

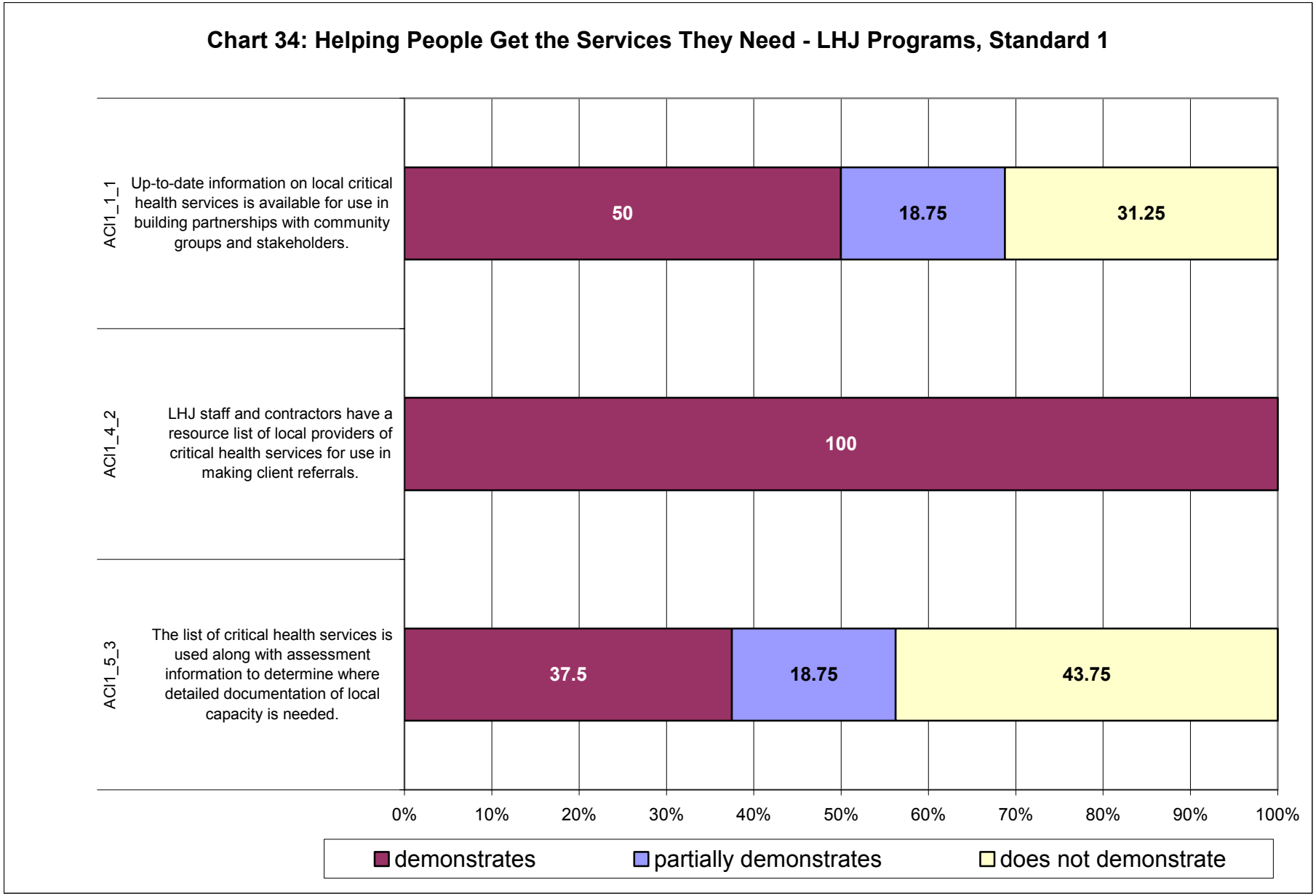
Chart 34: Helping People Get the Services They Need - LHJ Programs, Standard 1
ACI1_1_1
Up-to-date information on local critical health services is available for use in building partnerships with community groups and stakeholders.
50
18.75
31.25
ACI1_4_2
LHJ staff and contractors have a resource list of local providers of critical health services for use in making client referrals.
100
ACI1_5_3
The list of critical health services is used along with assessment information to determine where detailed documentation of local capacity is needed.
37.5
18.75
43.75
0%
10%
20%
30%
40%
50%
60%
70%
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100%
demonstrates
partially demonstrates
does not demonstrate

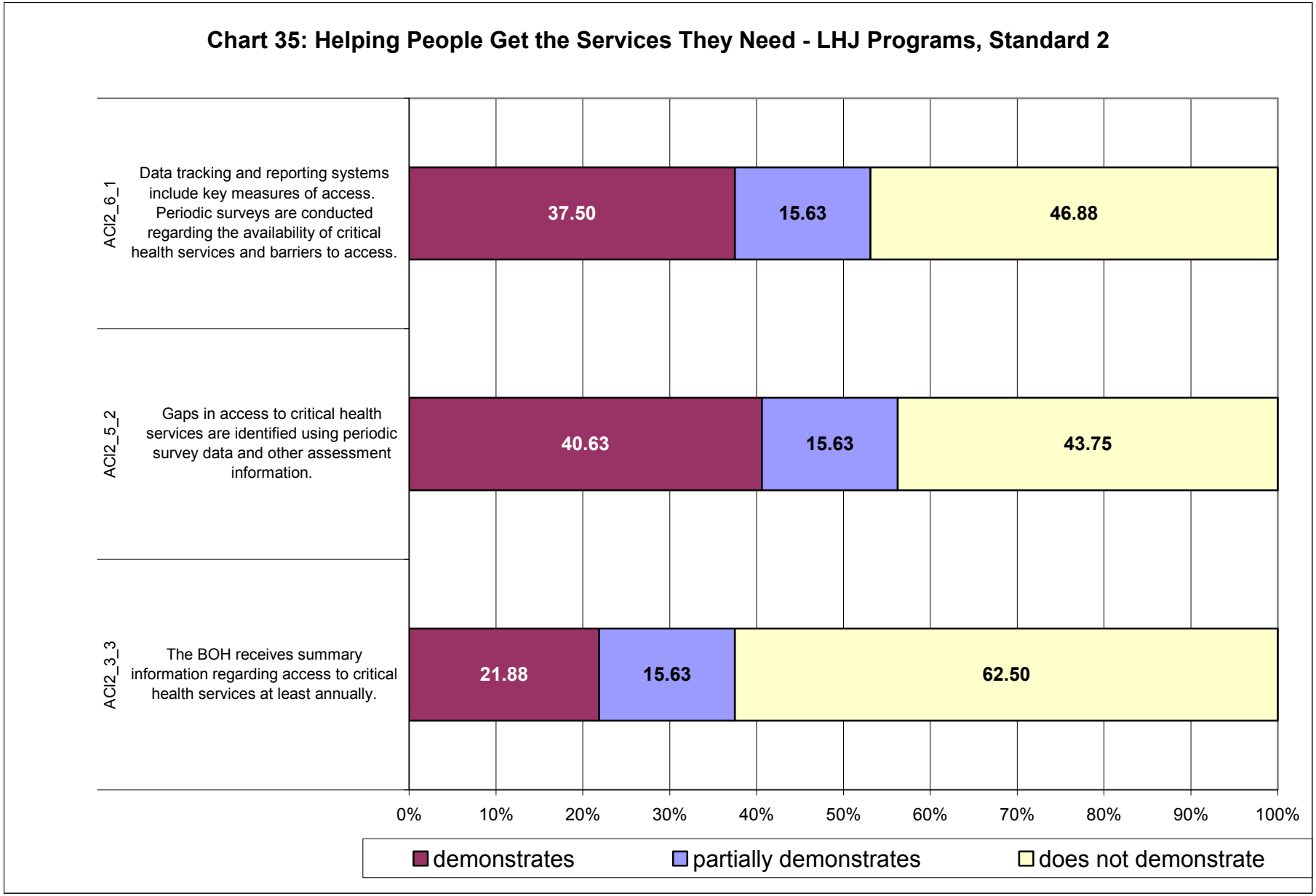
Chart 35: Helping People Get the Services They Need - LHJ Programs, Standard 2
ACI2_6_1
Data tracking and reporting systems include key measures of access. Periodic surveys are conducted regarding the availability of critical health services and barriers to access.
37.50
15.63
46.88
ACI2_5_2
Gaps in access to critical health services are identified using periodic survey data and other assessment information.
40.63
15.63
43.75
ACI2_3_3
The BOH receives summary information regarding access to critical health services at least annually.
21.88
15.63
62.50
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
does not demonstrate

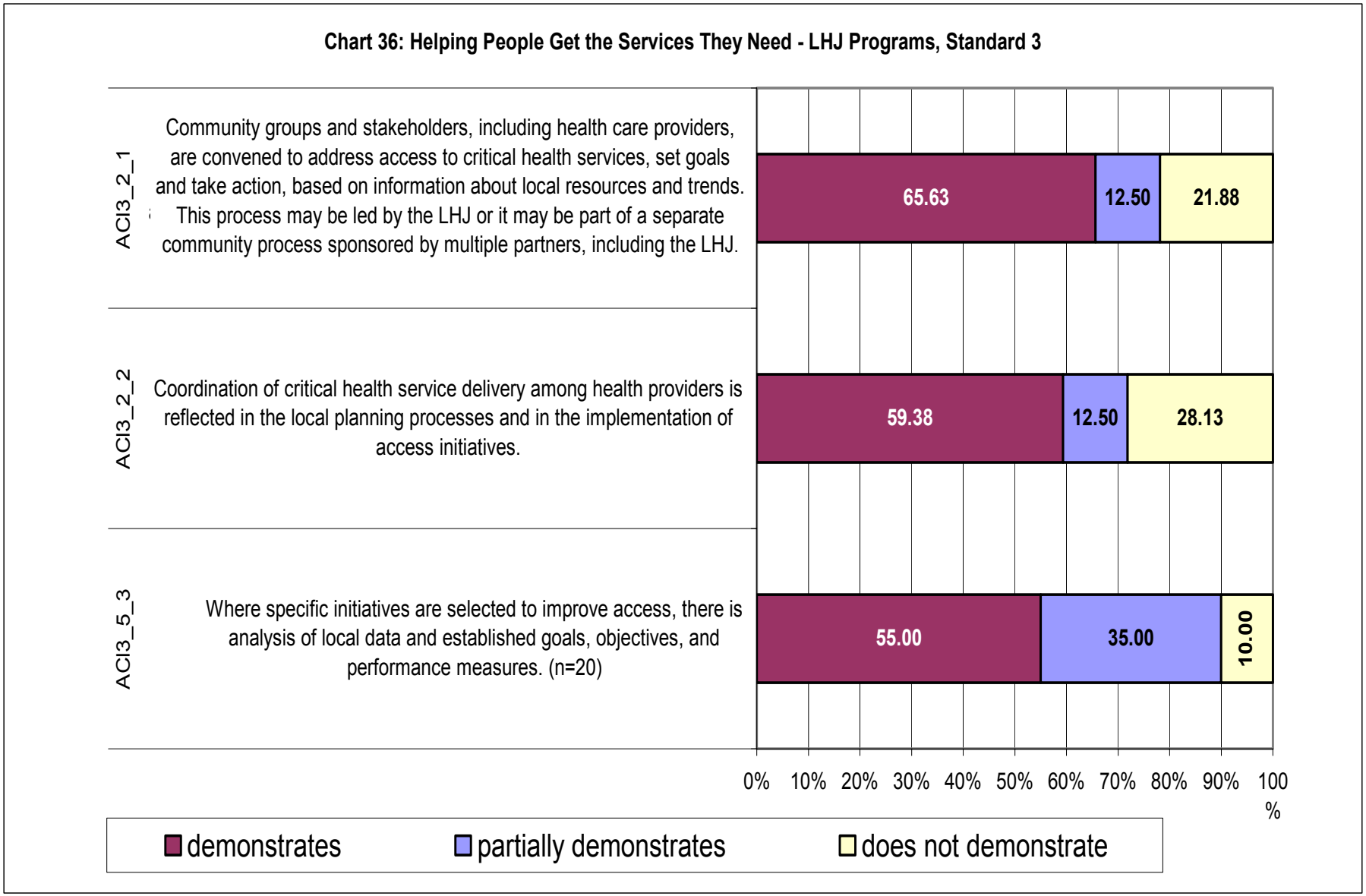
Chart 36: Helping People Get the Services They Need - LHJ Programs, Standard 3
ACI3_2_1
Community groups and stakeholders, including health care providers, are convened to address access to critical health services, set goals and take action, based on information about local resources and trends. This process may be led by the LHJ or it may be part of a separate community process sponsored by multiple partners, including the LHJ.
65.63
12.50
21.88
ACI3_2_2
Coordination of critical health service delivery among health providers is reflected in the local planning processes and in the implementation of access initiatives.
59.38
12.50
28.13
ACI3_5_3
Where specific initiatives are selected to improve access, there is analysis of local data and established goals, objectives, and performance measures. (n=20)
55.00
35.00
10.00
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100 %
demonstrates
partially demonstrates
does not demonstrate

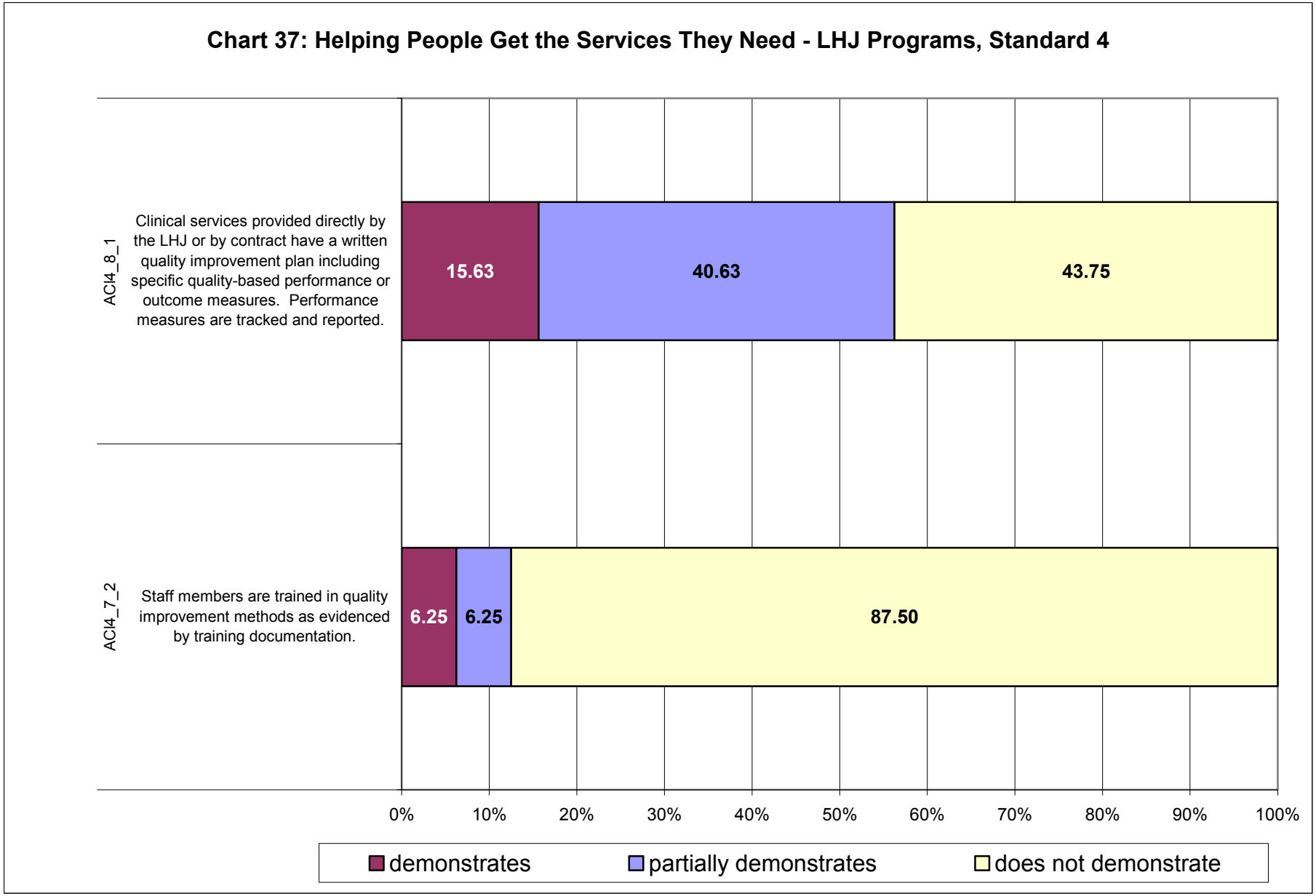
Chart 37: Helping People Get the Services They Need - LHJ Programs, Standard 4
ACI4_8_1
Clinical services provided directly by the LHJ or by contract have a written quality improvement plan including specific quality-based performance or outcome measures. Performance measures are tracked and reported.
15.63
40.63
43.75
ACI4_7_2
Staff members are trained in quality improvement methods as evidenced by training documentation.
6.25
6.25
87.50
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
demonstrates
partially demonstrates
does not demonstrate

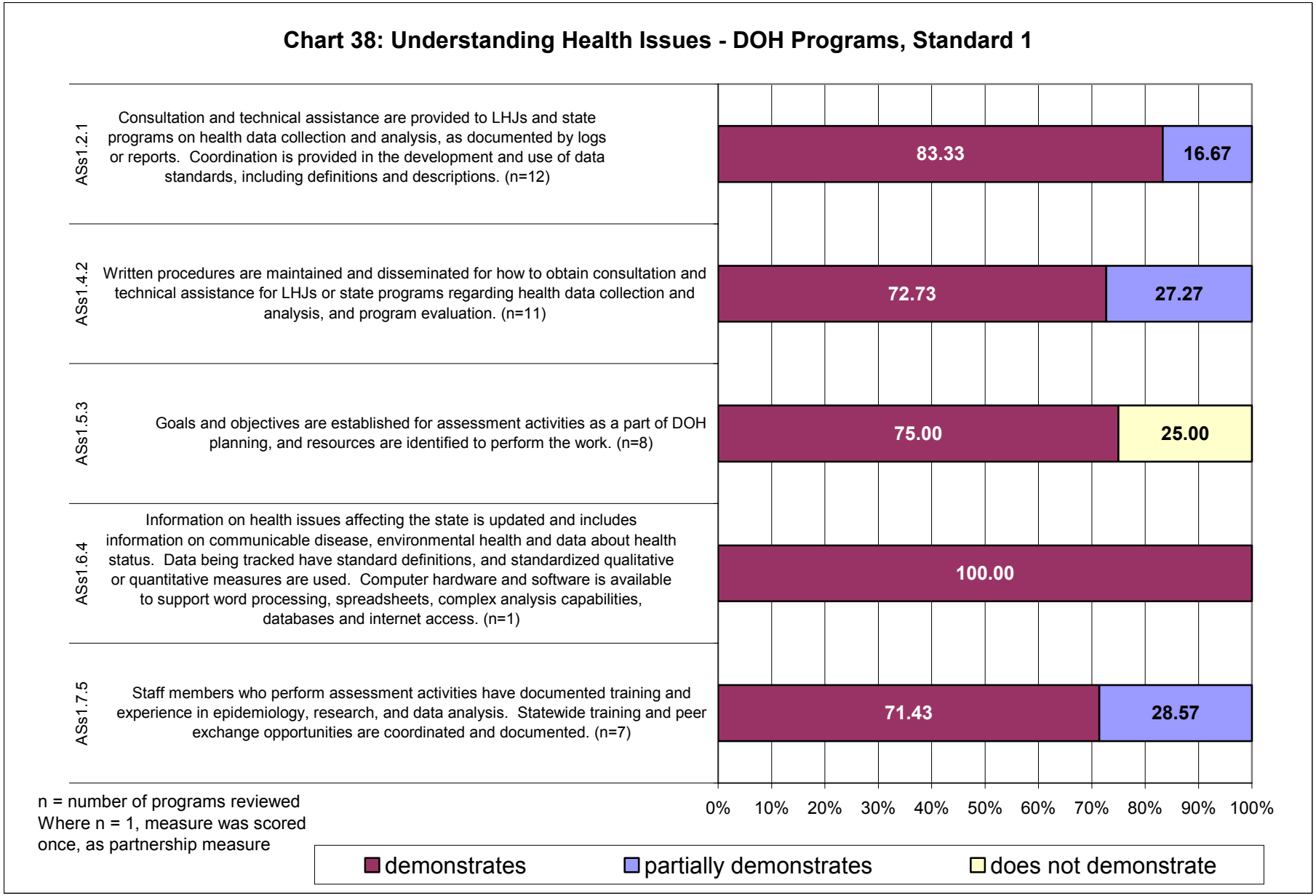
Chart 38: Understanding Health Issues - DOH Programs, Standard 1
ASs1.2.1
Consultation and technical assistance are provided to LHJs and state programs on health data collection and analysis, as documented by logs or reports. Coordination is provided in the development and use of data standards, including definitions and descriptions. (n=12)
83.33
16.67
ASs1.4.2
Written procedures are maintained and disseminated for how to obtain consultation and technical assistance for LHJs or state programs regarding health data collection and analysis, and program evaluation. (n=11)
72.73
27.27
ASs1.5.3
Goals and objectives are established for assessment activities as a part of DOH planning, and resources are identified to perform the work. (n=8)
75.00
25.00
ASs1.6.4
Information on health issues affecting the state is updated and includes information on communicable disease, environmental health and data about health status. Data being tracked have standard definitions, and standardized qualitative or quantitative measures are used. Computer hardware and software is available to support word processing, spreadsheets, complex analysis capabilities, databases and internet access. (n=1)
100.00
ASs1.7.5
Staff members who perform assessment activities have documented training and experience in epidemiology, research, and data analysis. Statewide training and peer exchange opportunities are coordinated and documented. (n=7)
71.43
28.57
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
n = number of programs reviewed
Where n = 1, measure was scored once, as partnership measure
demonstrates
partially demonstrates
does not demonstrate

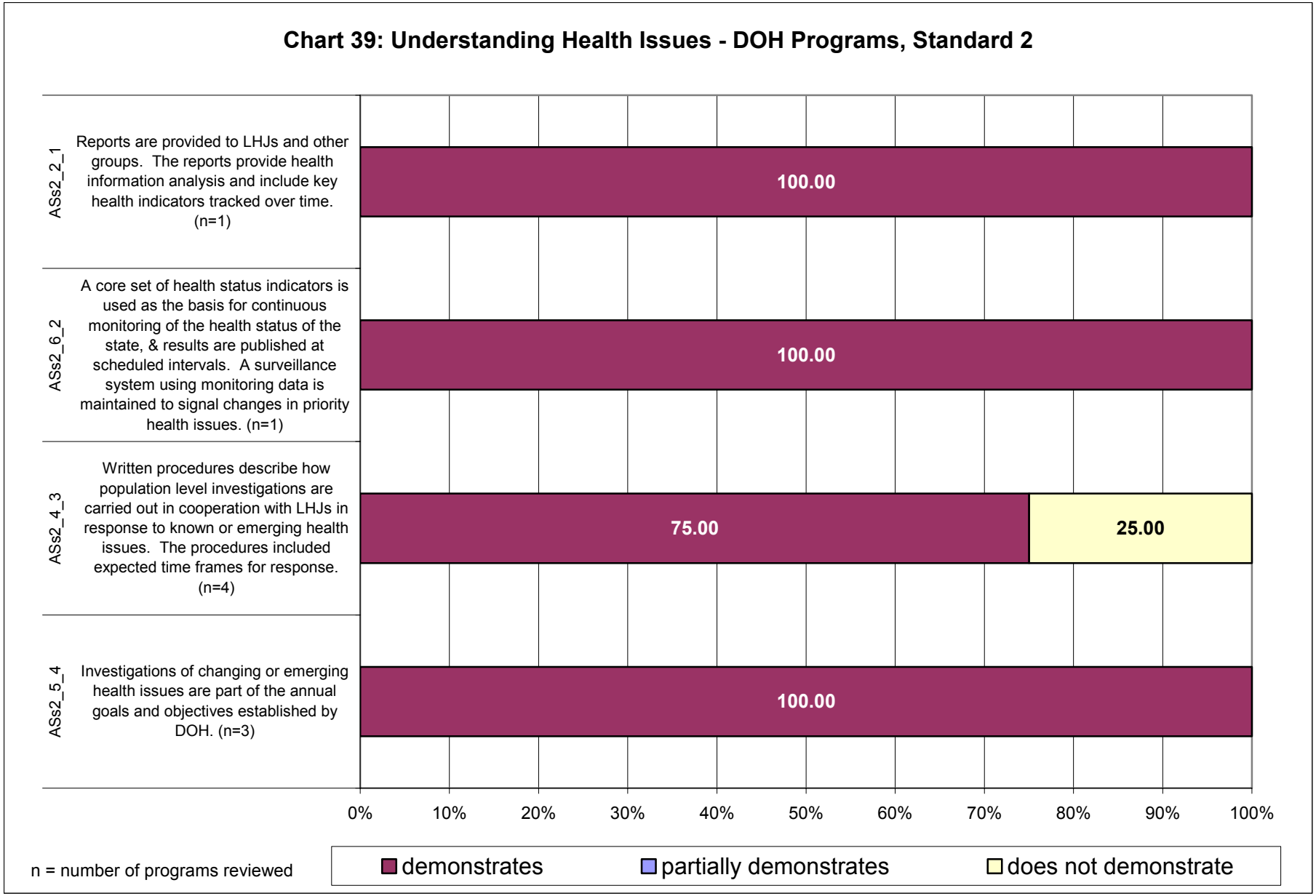
Chart 39: Understanding Health Issues - DOH Programs, Standard 2
ASs2_2_1
Reports are provided to LHJs and other groups. The reports provide health information analysis and include key health indicators tracked over time. (n=1)
100.00
ASs2_6_2
A core set of health status indicators is used as the basis for continuous monitoring of the health status of the state, & results are published at scheduled intervals. A surveillance system using monitoring data is maintained to signal changes in priority health issues. (n=1)
100.00
ASs2_4_3
Written procedures describe how population level investigations are carried out in cooperation with LHJs in response to known or emerging health issues. The procedures included expected time frames for response. (n=4)
75.00
25.00
ASs2_5_4
Investigations of changing or emerging health issues are part of the annual goals and objectives established by DOH. (n=3)
100.00
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = number of programs reviewed
demonstrates
partially demonstrates
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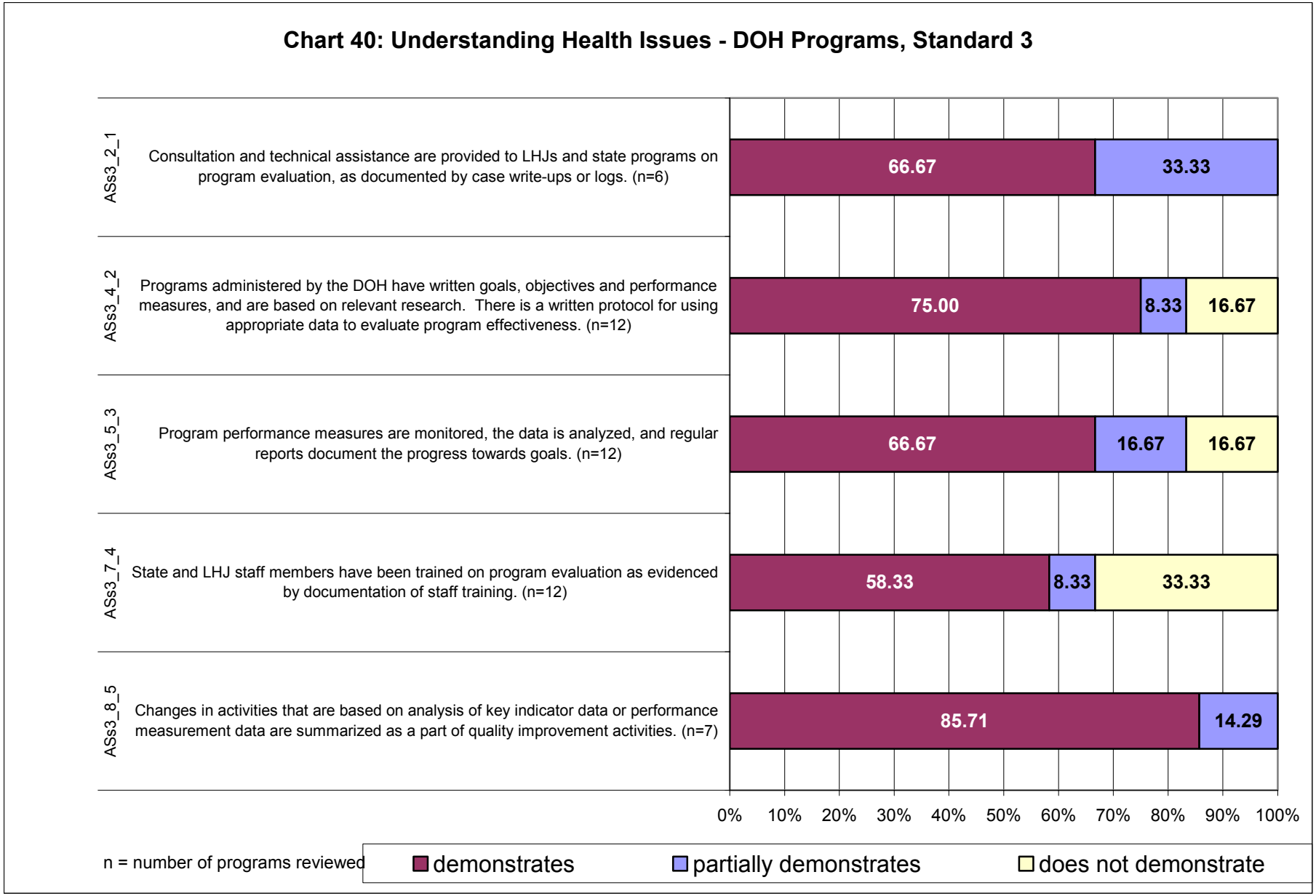
Chart 40: Understanding Health Issues - DOH Programs, Standard 3
ASs3_2_1
Consultation and technical assistance are provided to LHJs and state programs on program evaluation, as documented by case write-ups or logs. (n=6)
66.67
33.33
ASs3_4_2
Programs administered by the DOH have written goals, objectives and performance measures, and are based on relevant research. There is a written protocol for using appropriate data to evaluate program effectiveness. (n=12)
75.00
8.33
16.67
ASs3_5_3
Program performance measures are monitored, the data is analyzed, and regular reports document the progress towards goals. (n=12)
66.67
16.67
16.67
ASs3_7_4
State and LHJ staff members have been trained on program evaluation as evidenced by documentation of staff training. (n=12)
58.33
8.33
33.33
ASs3_8_5
Changes in activities that are based on analysis of key indicator data or performance measurement data are summarized as a part of quality improvement activities. (n=7)
85.71
14.29
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = number of programs reviewed
demonstrates
partially demonstrates
does not demonstrate

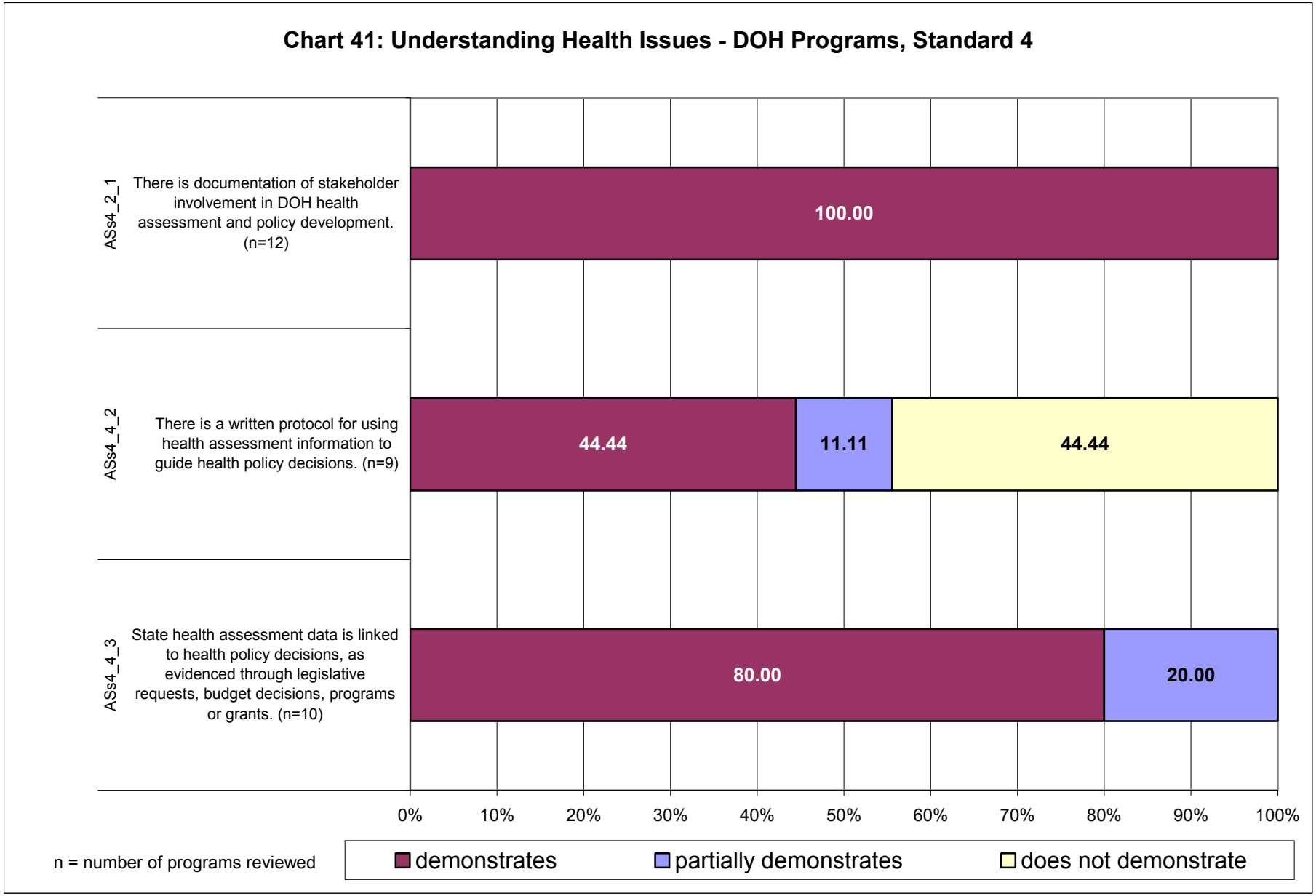
Chart 41: Understanding Health Issues - DOH Programs, Standard 4
ASs4_2_1
There is documentation of stakeholder involvement in DOH health assessment and policy development. (n=12)
100.00
ASs4_4_2
There is a written protocol for using health assessment information to guide health policy decisions. (n=9)
44.44
11.11
44.44
ASs4_4_3
State health assessment data is linked to health policy decisions, as evidenced through legislative requests, budget decisions, programs or grants. (n=10)
80.00
20.00
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = number of programs reviewed
demonstrates
partially demonstrates
does not demonstrate

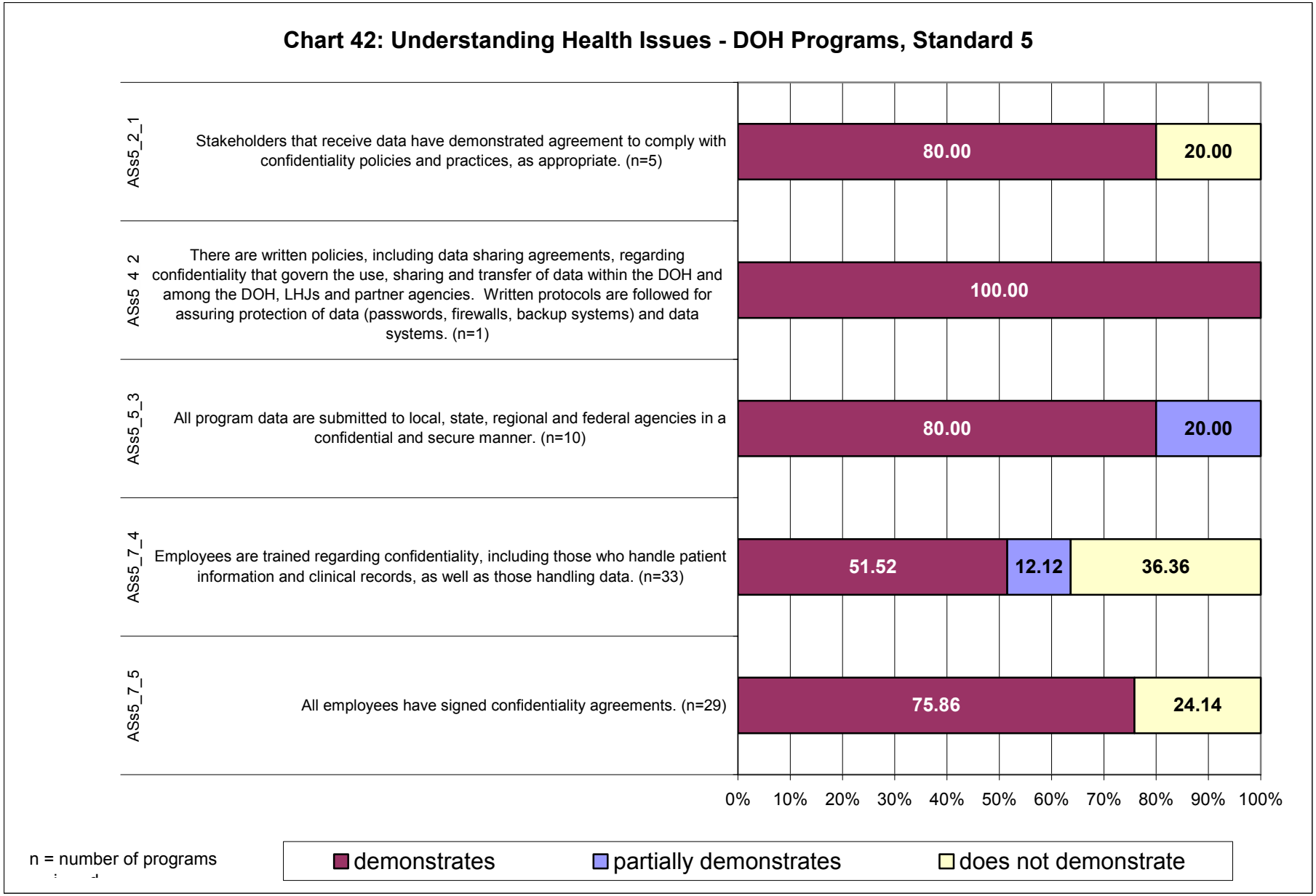
Chart 42: Understanding Health Issues - DOH Programs, Standard 5
ASs5_2_1
Stakeholders that receive data have demonstrated agreement to comply with confidentiality policies and practices, as appropriate. (n=5)
80.00
20.00
ASs5_4_2
There are written policies, including data sharing agreements, regarding confidentiality that govern the use, sharing and transfer of data within the DOH and among the DOH, LHJs and partner agencies. Written protocols are followed for assuring protection of data (passwords, firewalls, backup systems) and data systems. (n=1)
100.00
ASs5_5_3
All program data are submitted to local, state, regional and federal agencies in a confidential and secure manner. (n=10)
80.00
20.00
ASs5_7_4
Employees are trained regarding confidentiality, including those who handle patient information and clinical records, as well as those handling data. (n=33)
51.52
12.12
36.36
ASs5_7_5
All employees have signed confidentiality agreements. (n=29)
75.86
24.14
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = number of programs
demonstrates
partially demonstrates
does not demonstrate

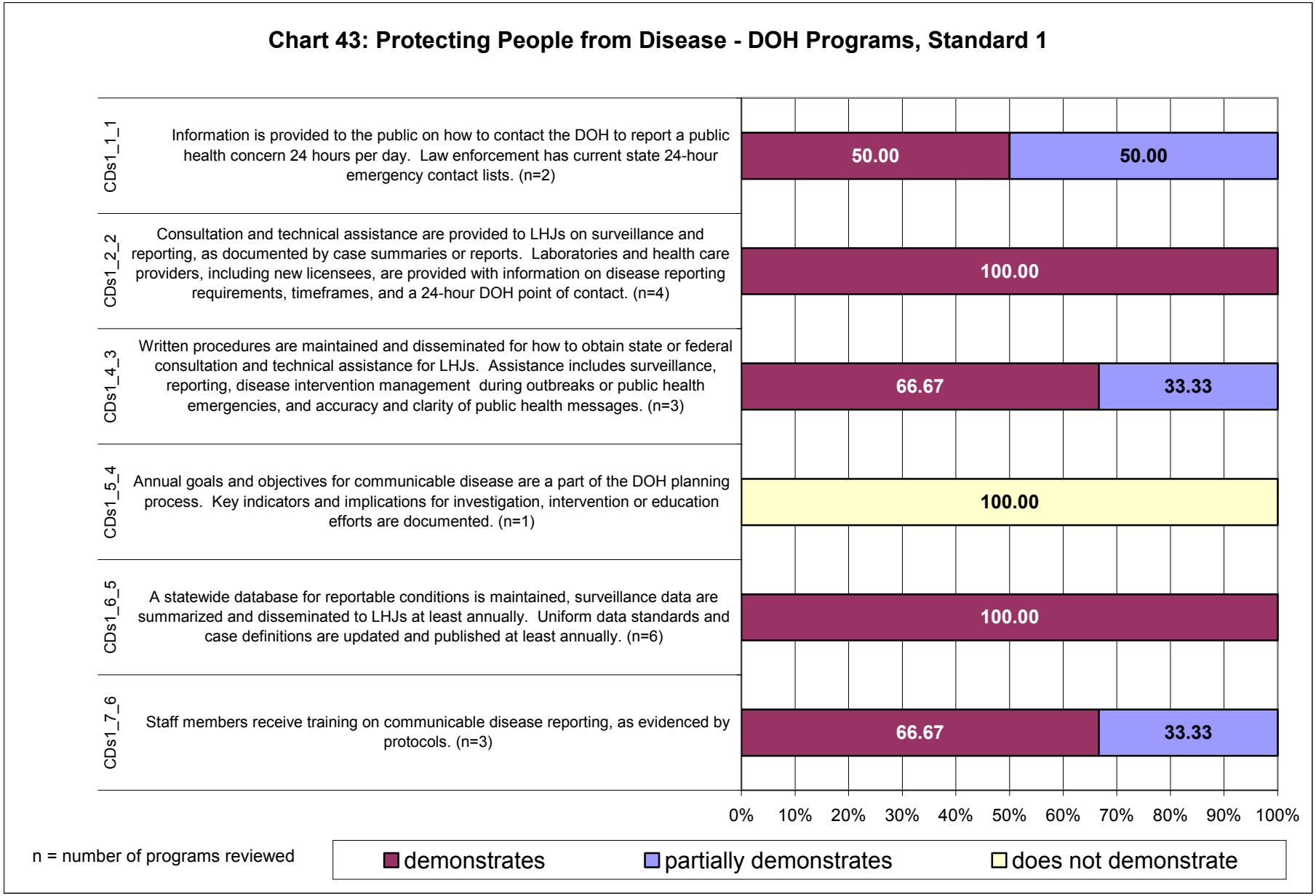
Chart 43: Protecting People from Disease - DOH Programs, Standard 1
CDs1_1_1
Information is provided to the public on how to contact the DOH to report a public health concern 24 hours per day. Law enforcement has current state 24-hour emergency contact lists. (n=2)
50.00
50.00
CDs1_2_2
Consultation and technical assistance are provided to LHJs on surveillance and reporting, as documented by case summaries or reports. Laboratories and health care providers, including new licensees, are provided with information on disease reporting requirements, timeframes, and a 24-hour DOH point of contact. (n=4)
100.00
CDs1_4_3
Written procedures are maintained and disseminated for how to obtain state or federal consultation and technical assistance for LHJs. Assistance includes surveillance, reporting, disease intervention management during outbreaks or public health emergencies, and accuracy and clarity of public health messages. (n=3)
66.67
33.33
CDs1_5_4
Annual goals and objectives for communicable disease are a part of the DOH planning process. Key indicators and implications for investigation, intervention or education efforts are documented. (n=1)
100.00
CDs1_6_5
A statewide database for reportable conditions is maintained, surveillance data are summarized and disseminated to LHJs at least annually. Uniform data standards and case definitions are updated and published at least annually. (n=6)
100.00
CDs1_7_6
Staff members receive training on communicable disease reporting, as evidenced by protocols. (n=3)
66.67
33.33
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = number of programs reviewed
demonstrates
partially demonstrates
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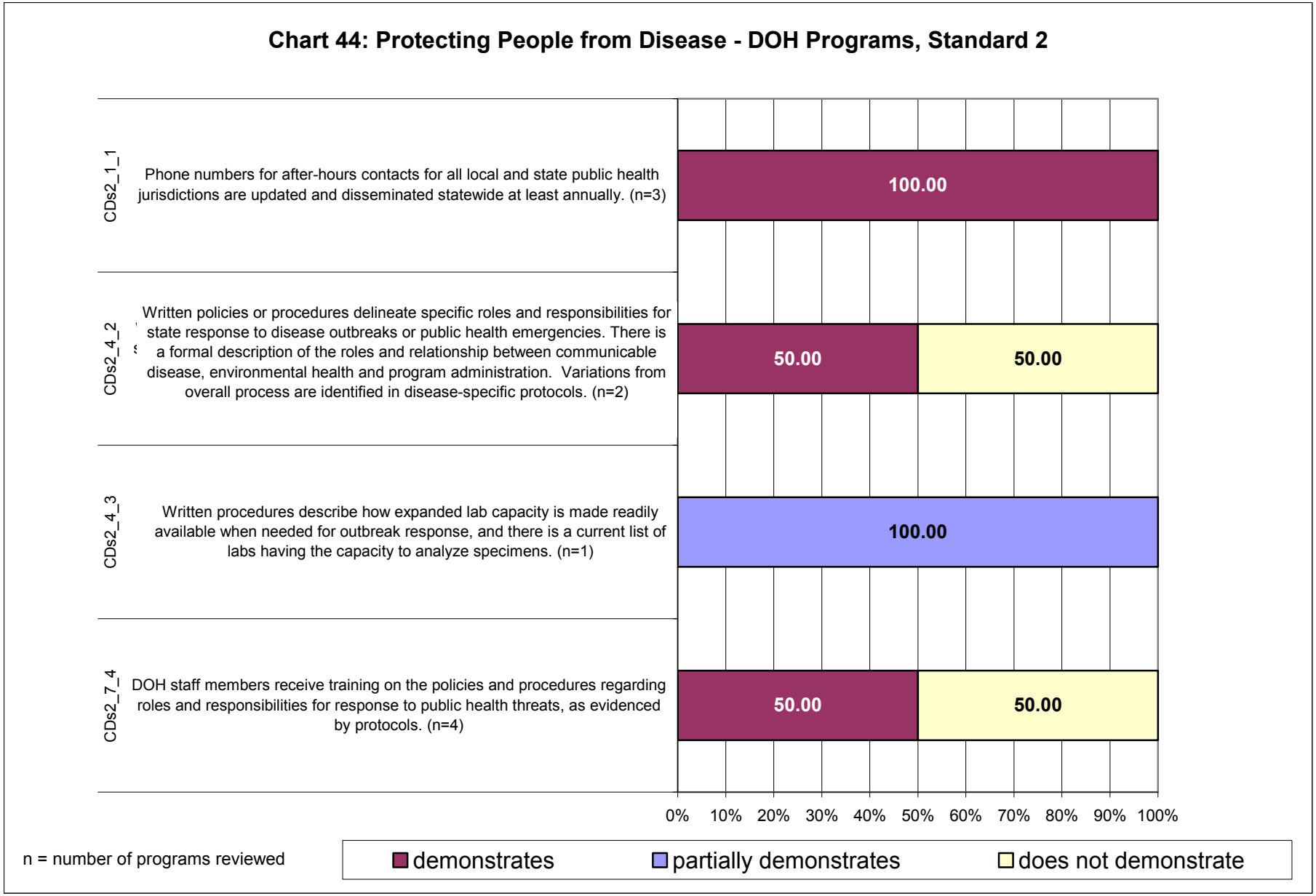


Chart 44: Protecting People from Disease - DOH Programs, Standard 2
CDs2_1_1
Phone numbers for after-hours contacts for all local and state public health jurisdictions are updated and disseminated statewide at least annually. (n=3)
100.00
CDs2_4_2
Written policies or procedures delineate specific roles and responsibilities for state response to disease outbreaks or public health emergencies. There is a formal description of the roles and relationship between communicable disease, environmental health and program administration. Variations from overall process are identified in disease-specific protocols. (n=2)
50.00
50.00
CDs2_4_3
Written procedures describe how expanded lab capacity is made readily available when needed for outbreak response, and there is a current list of labs having the capacity to analyze specimens. (n=1)
100.00
CDs2_7_4
DOH staff members receive training on the policies and procedures regarding roles and responsibilities for response to public health threats, as evidenced by protocols. (n=4)
50.00
50.00
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
n = number of programs reviewed
demonstrates
partially demonstrates
does not demonstrate

Chart 45: Protecting People from Disease - DOH Programs, Standard 3

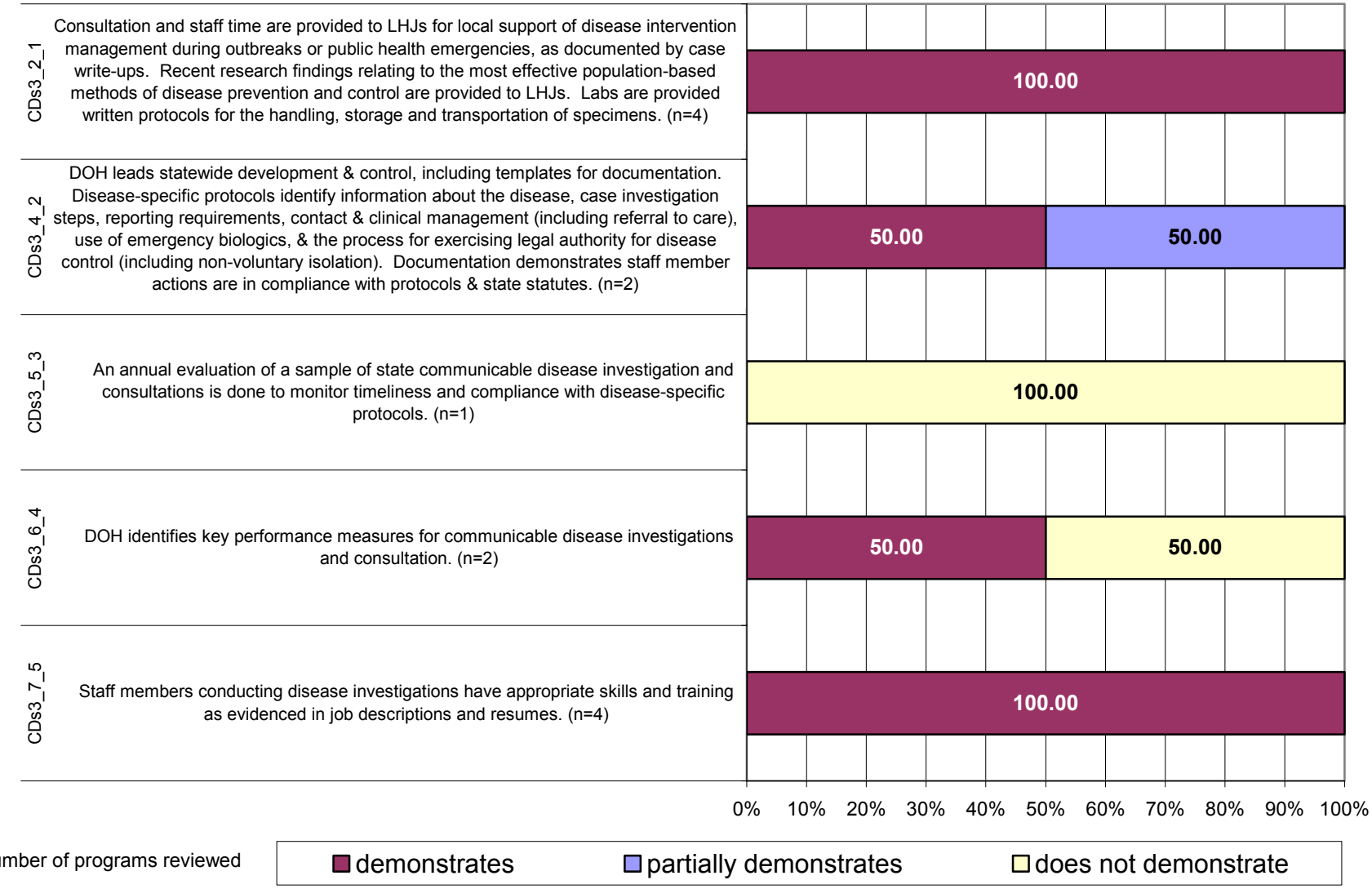
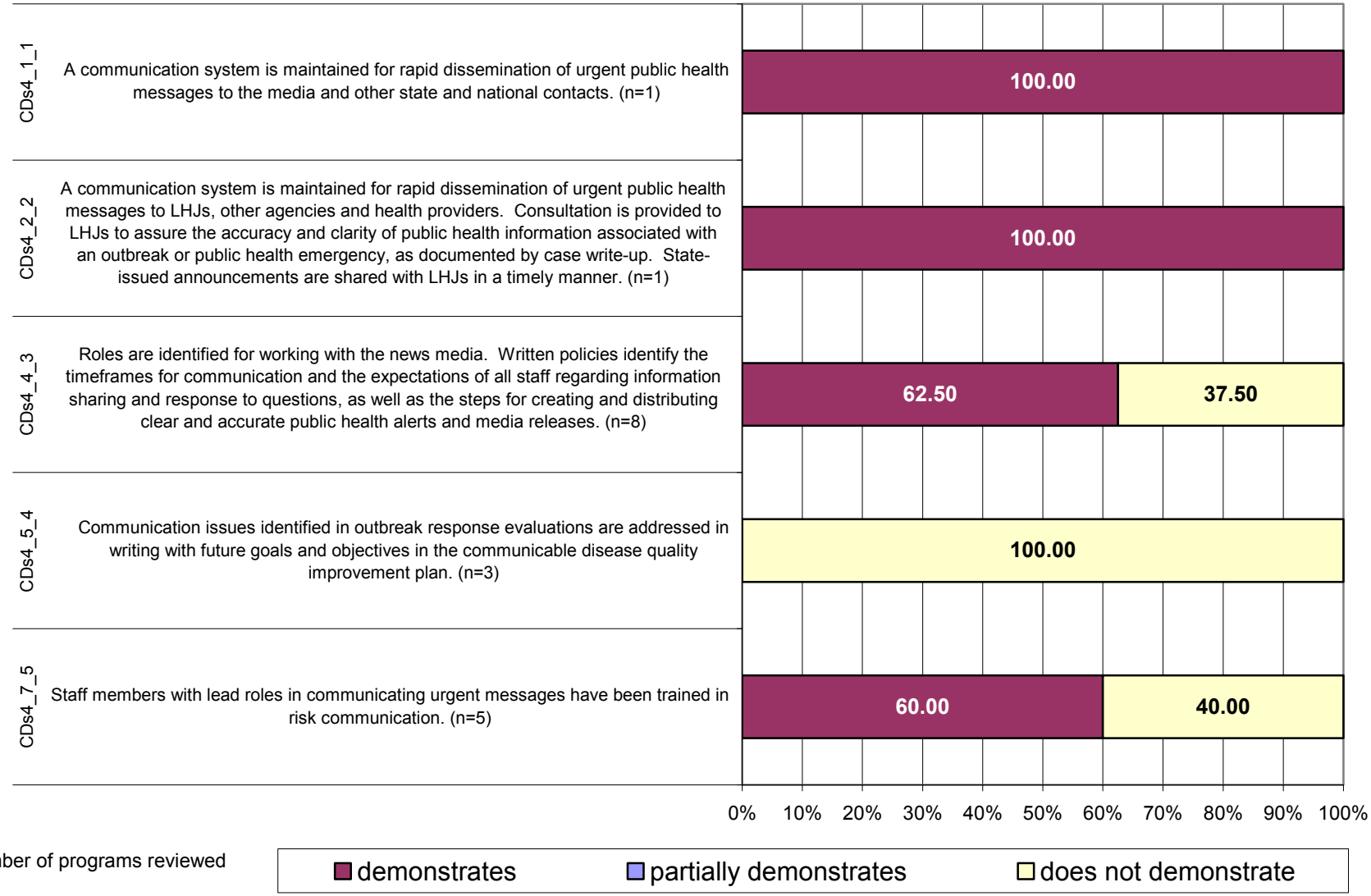


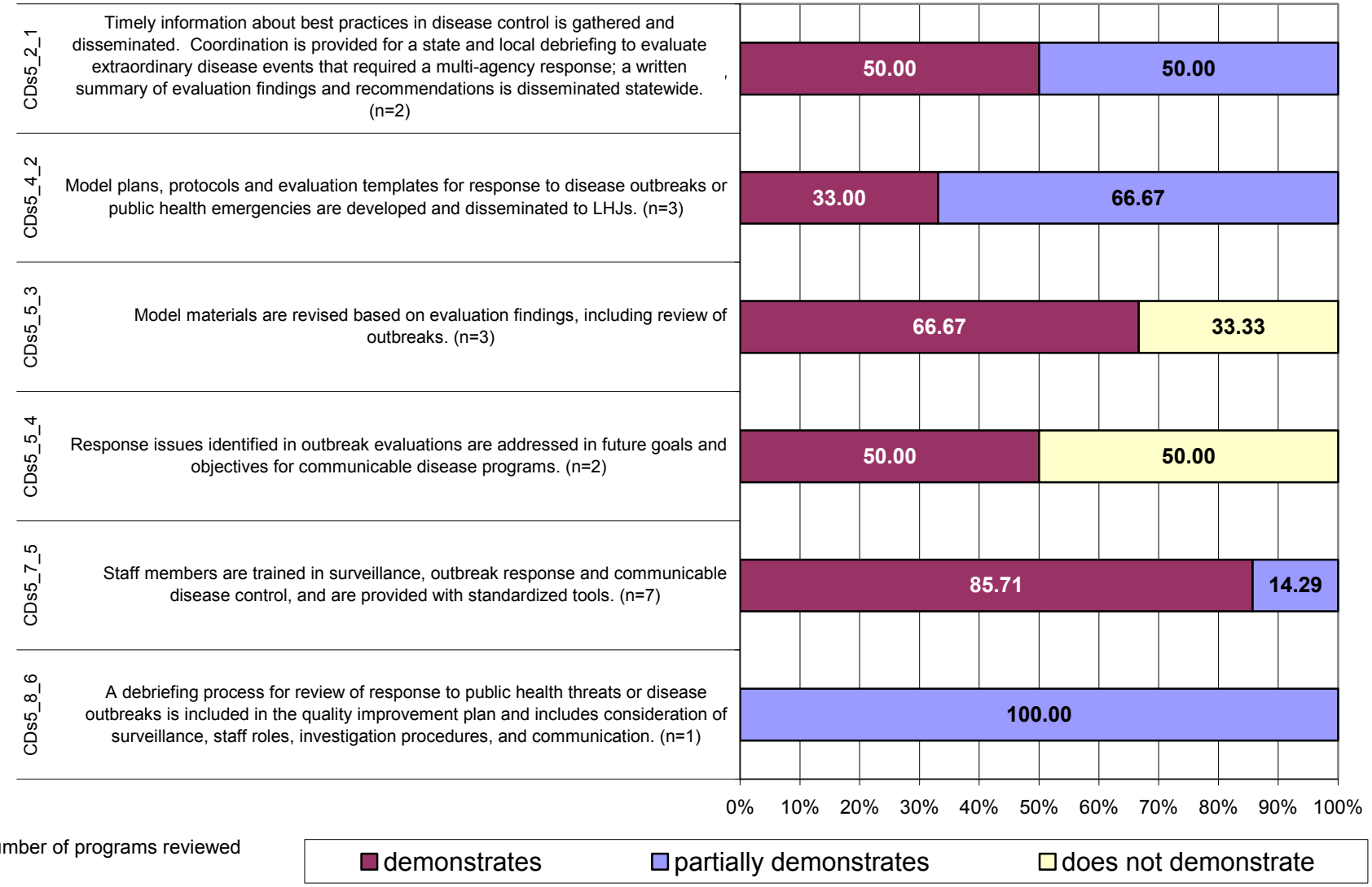
Chart 46: Protecting People from Disease - DOH Programs, Standard 4



n = number of programs reviewed

demonstrates | partially demonstrates | does not demonstrate

Chart 47: Protecting People from Disease - DOH Programs, Standard 5



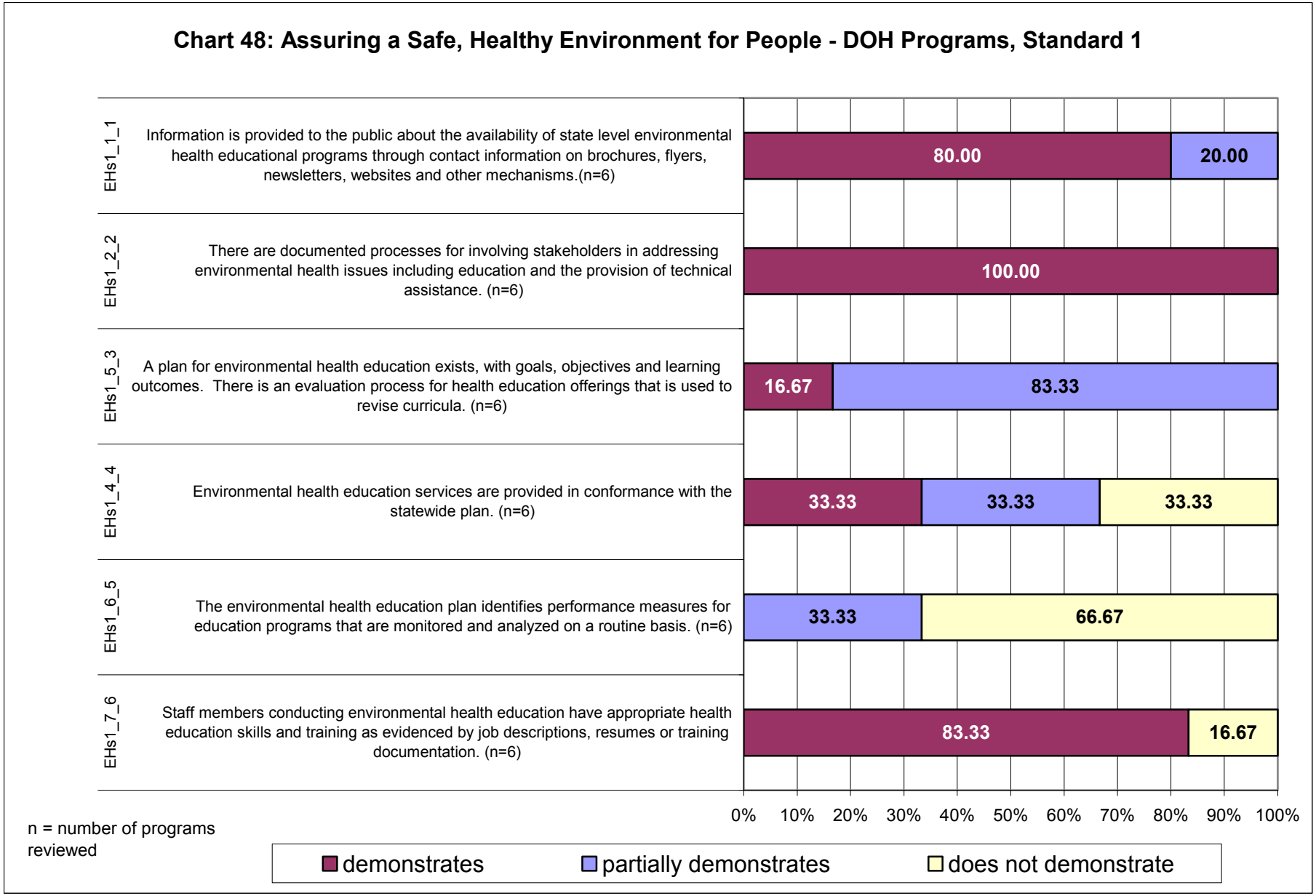
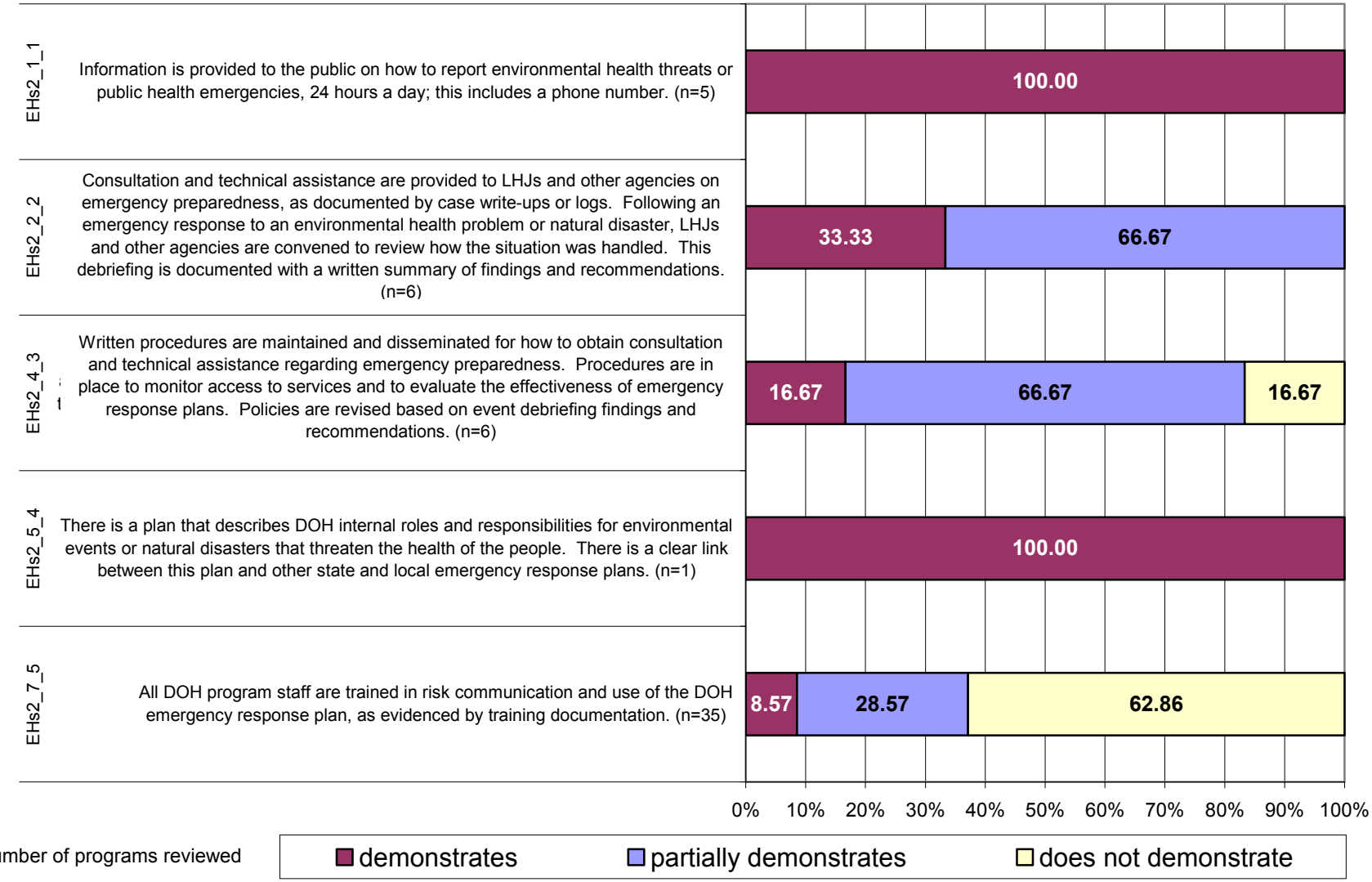


Chart 48: Assuring a Safe, Healthy Environment for People - DOH Programs, Standard 1
EHs1_1_1
Information is provided to the public about the availability of state level environmental health educational programs through contact information on brochures, flyers, newsletters, websites and other mechanisms.(n=6)
80.00
20.00
EHs1_2_2
There are documented processes for involving stakeholders in addressing environmental health issues including education and the provision of technical assistance. (n=6)
100.00
EHs1_5_3
A plan for environmental health education exists, with goals, objectives and learning outcomes. There is an evaluation process for health education offerings that is used to revise curricula. (n=6)
16.67
83.33
EHs1_4_4
Environmental health education services are provided in conformance with the statewide plan. (n=6)
33.33
33.33
33.33
EHs1_6_5
The environmental health education plan identifies performance measures for education programs that are monitored and analyzed on a routine basis. (n=6)
33.33
66.67
EHs1_7_6
Staff members conducting environmental health education have appropriate health education skills and training as evidenced by job descriptions, resumes or training documentation. (n=6)
83.33
16.67
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
n = number of programs reviewed
demonstrates
partially demonstrates
does not demonstrate

Chart 49: Assuring a Safe, Healthy Environment for People - DOH Programs, Standard 2



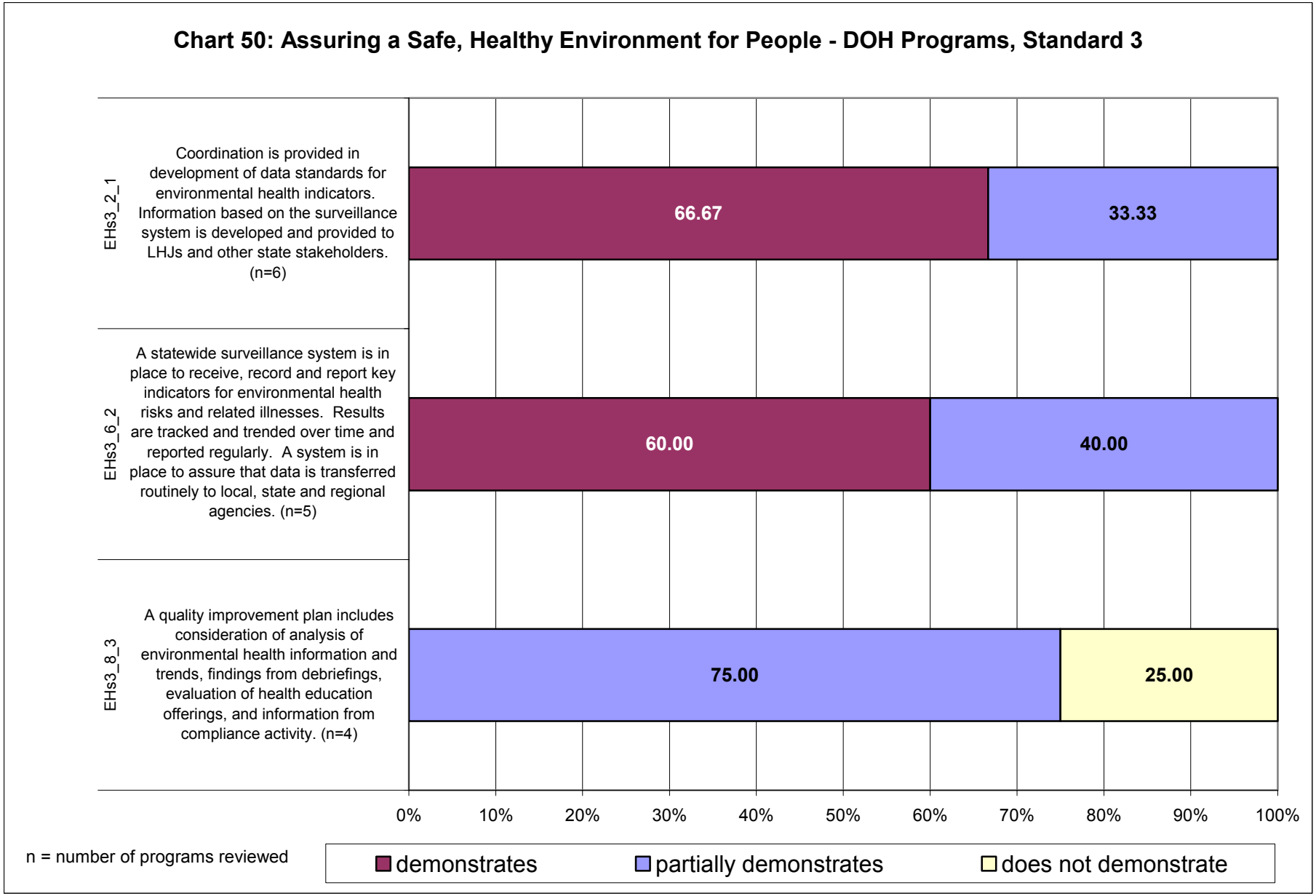


Chart 50: Assuring a Safe, Healthy Environment for People - DOH Programs, Standard 3
EHs3_2_1
Coordination is provided in development of data standards for environmental health indicators. Information based on the surveillance system is developed and provided to LHJs and other state stakeholders. (n=6)
66.67
33.33
EHs3_6_2
A statewide surveillance system is in place to receive, record and report key indicators for environmental health risks and related illnesses. Results are tracked and trended over time and reported regularly. A system is in place to assure that data is transferred routinely to local, state and regional agencies. (n=5)
60.00
40.00
EHs3_8_3
A quality improvement plan includes consideration of analysis of environmental health information and trends, findings from debriefings, evaluation of health education offerings, and information from compliance activity. (n=4)
75.00
25.00
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = number of programs reviewed
demonstrates
partially demonstrates
does not demonstrate

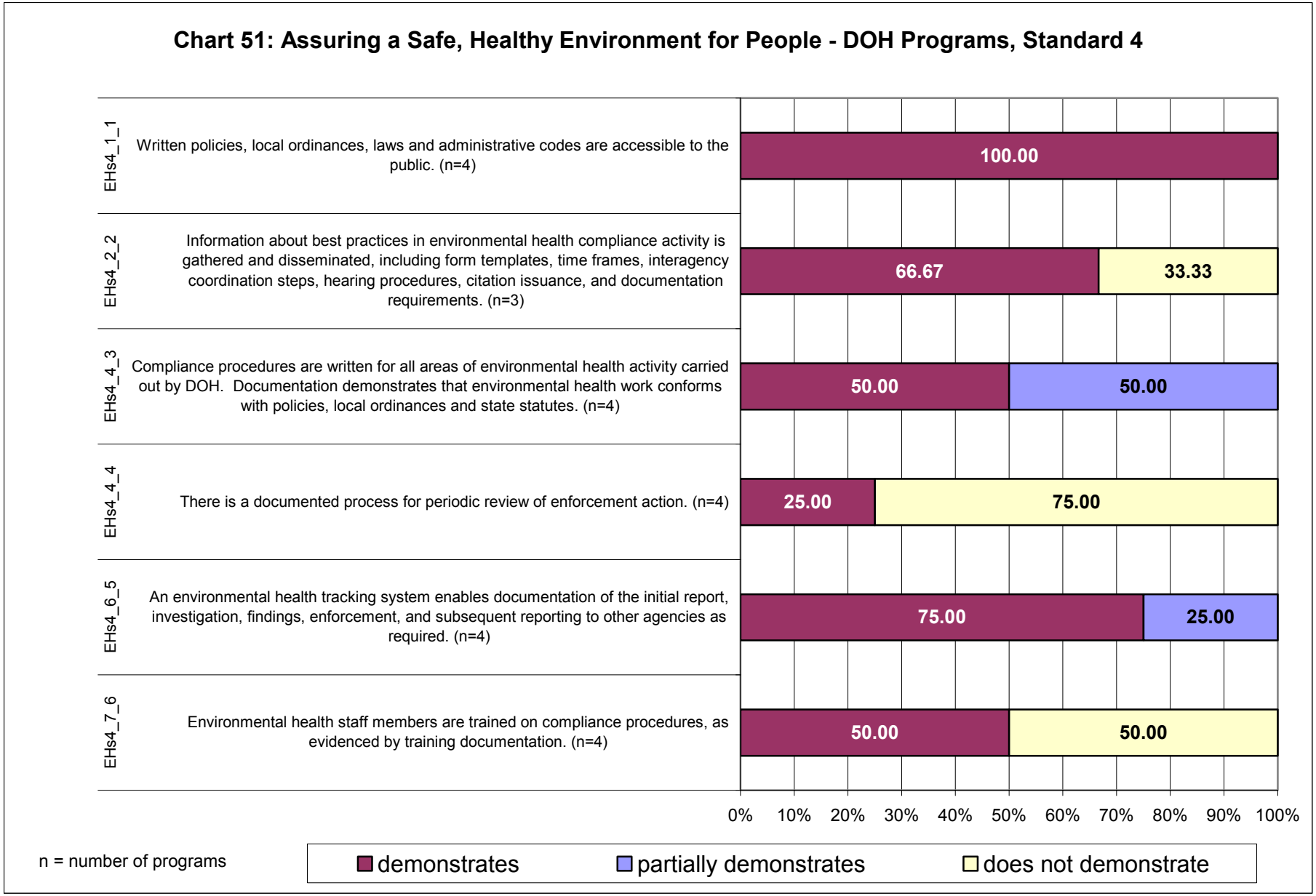
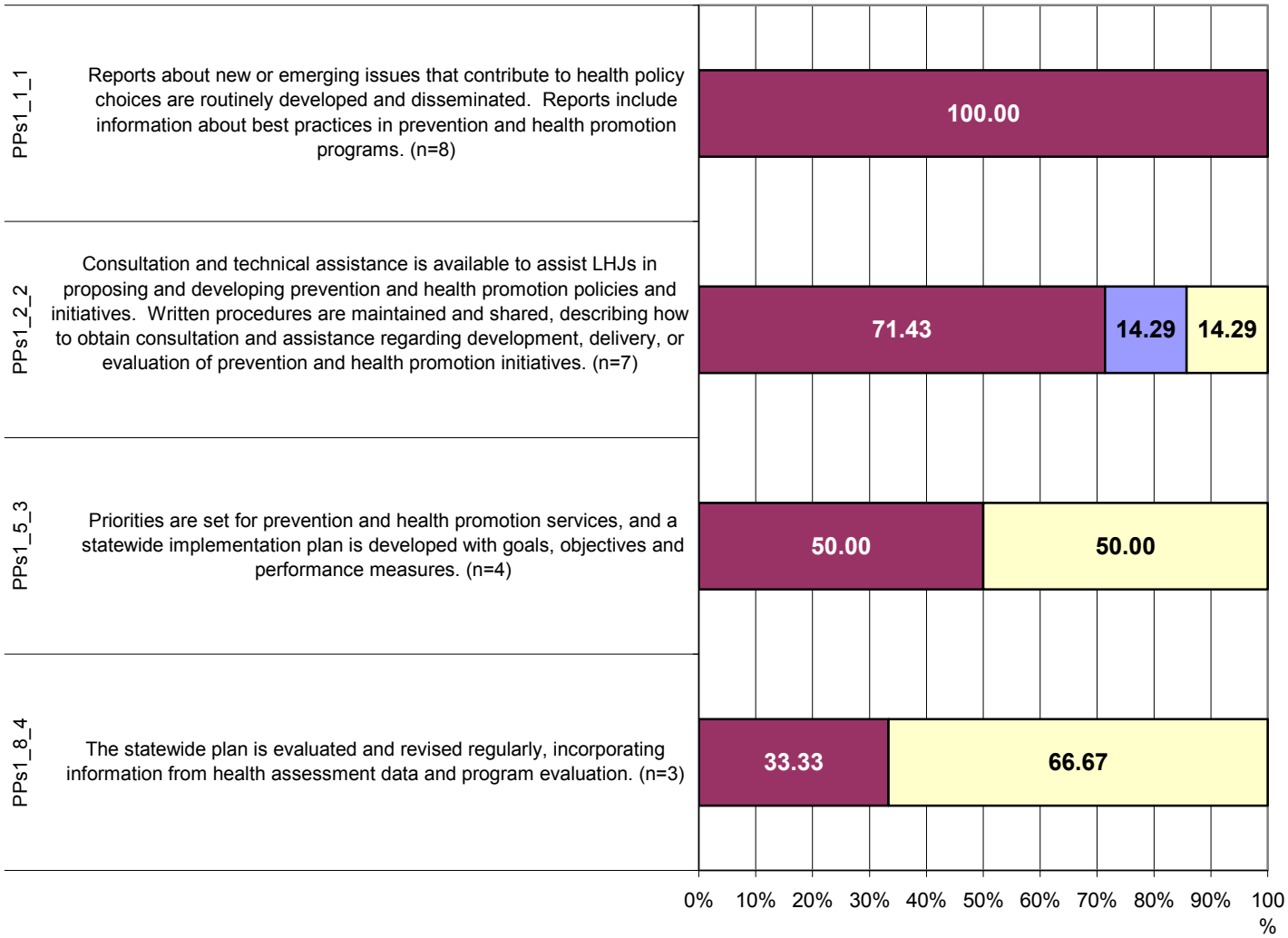


Chart 51: Assuring a Safe, Healthy Environment for People - DOH Programs, Standard 4
EHs4_1_1
Written policies, local ordinances, laws and administrative codes are accessible to the public. (n=4)
100.00
EHs4_2_2
Information about best practices in environmental health compliance activity is gathered and disseminated, including form templates, time frames, interagency coordination steps, hearing procedures, citation issuance, and documentation requirements. (n=3)
66.67
33.33
EHs4_4_3
Compliance procedures are written for all areas of environmental health activity carried out by DOH. Documentation demonstrates that environmental health work conforms with policies, local ordinances and state statutes. (n=4)
50.00
50.00
EHs4_4_4
There is a documented process for periodic review of enforcement action. (n=4)
25.00
75.00
EHs4_6_5
An environmental health tracking system enables documentation of the initial report, investigation, findings, enforcement, and subsequent reporting to other agencies as required. (n=4)
75.00
25.00
EHs4_7_6
Environmental health staff members are trained on compliance procedures, as evidenced by training documentation. (n=4)
50.00
50.00
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
n = number of programs
demonstrates
partially demonstrates
does not demonstrate

Chart 52: Prevention is Best: Promoting Healthy Living - DOH Programs, Standard 1



n = number of programs reviewed

demonstrates | partially demonstrates | does not demonstrate

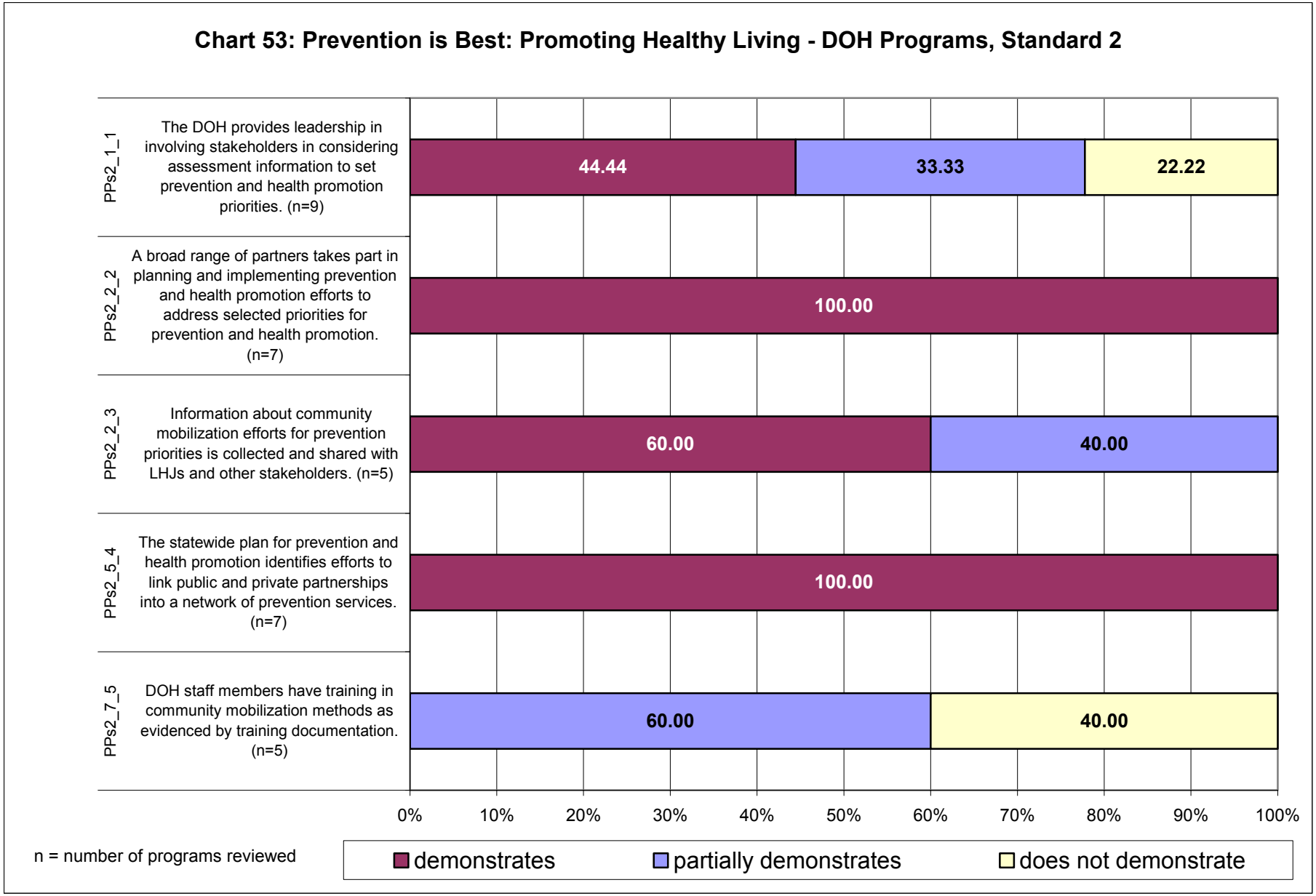
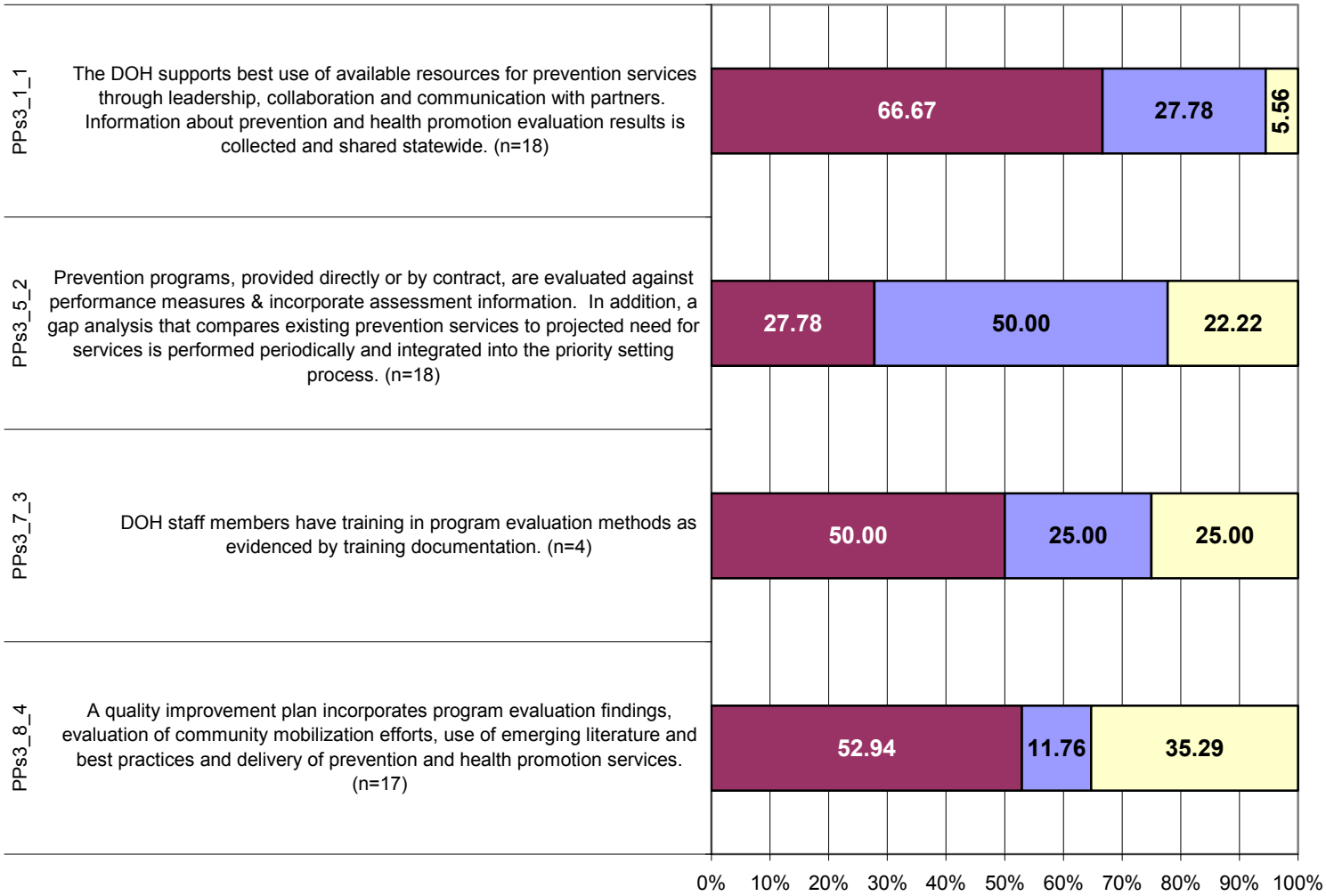


Chart 53: Prevention is Best: Promoting Healthy Living - DOH Programs, Standard 2
PPs2_1_1
The DOH provides leadership in involving stakeholders in considering assessment information to set prevention and health promotion priorities. (n=9)
44.44
33.33
22.22
PPs2_2_2
A broad range of partners takes part in planning and implementing prevention and health promotion efforts to address selected priorities for prevention and health promotion. (n=7)
100.00
PPs2_2_3
Information about community mobilization efforts for prevention priorities is collected and shared with LHJs and other stakeholders. (n=5)
60.00
40.00
PPs2_5_4
The statewide plan for prevention and health promotion identifies efforts to link public and private partnerships into a network of prevention services. (n=7)
100.00
PPs2_7_5
DOH staff members have training in community mobilization methods as evidenced by training documentation. (n=5)
60.00
40.00
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = number of programs reviewed
demonstrates
partially demonstrates
does not demonstrate

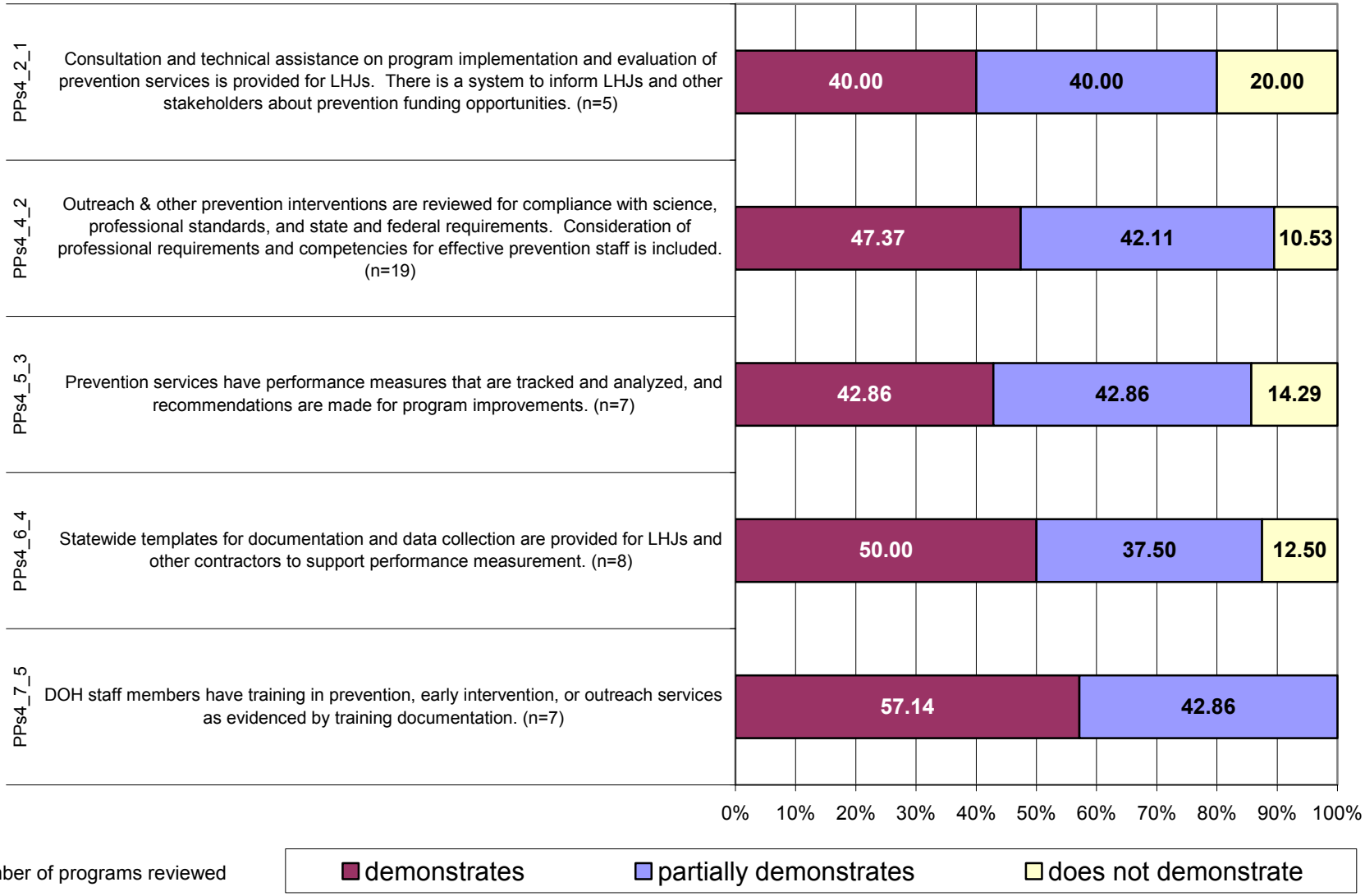
Chart 54: Prevention is Best: Promoting Healthy Living - DOH Programs, Standard 3



n = number of programs reviewed

demonstrates | partially demonstrates | does not demonstrate

Chart 55: Prevention is Best: Promoting Healthy Living - DOH Programs, Standard 4



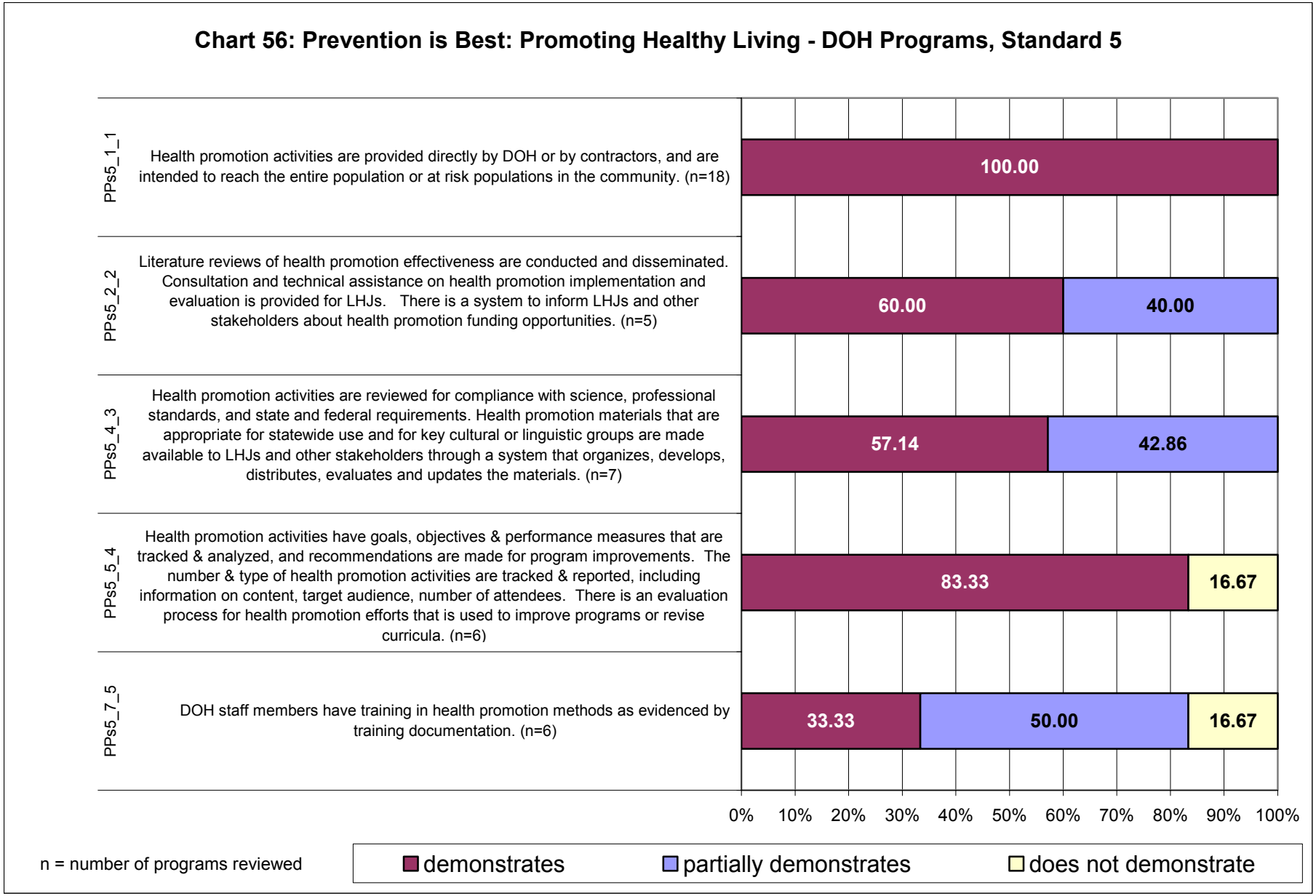
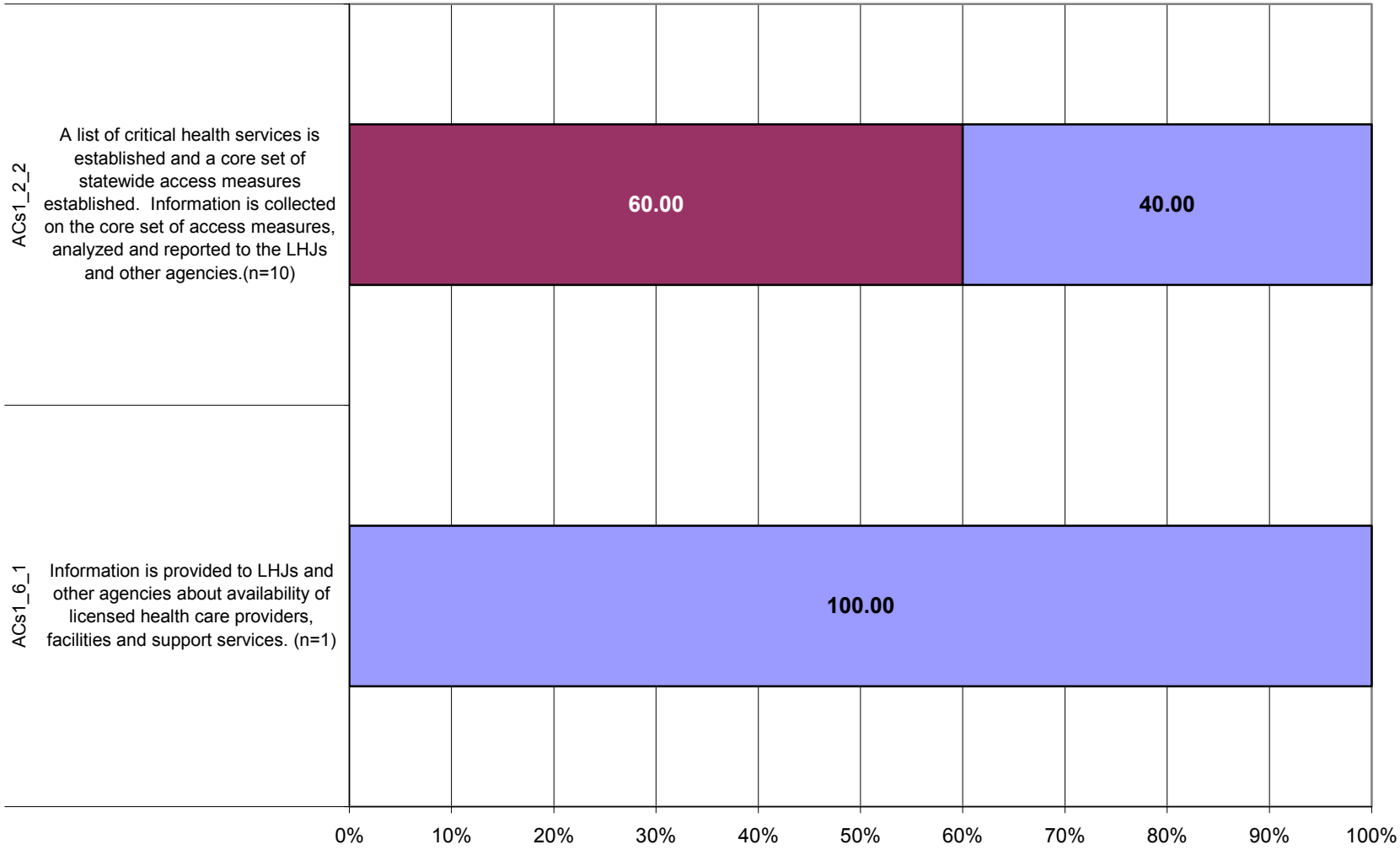


Chart 56: Prevention is Best: Promoting Healthy Living - DOH Programs, Standard 5
PPs5_1_1
Health promotion activities are provided directly by DOH or by contractors, and are intended to reach the entire population or at risk populations in the community. (n=18)
100.00
PPs5_2_2
Literature reviews of health promotion effectiveness are conducted and disseminated. Consultation and technical assistance on health promotion implementation and evaluation is provided for LHJs. There is a system to inform LHJs and other stakeholders about health promotion funding opportunities. (n=5)
60.00
40.00
PPs5_4_3
Health promotion activities are reviewed for compliance with science, professional standards, and state and federal requirements. Health promotion materials that are appropriate for statewide use and for key cultural or linguistic groups are made available to LHJs and other stakeholders through a system that organizes, develops, distributes, evaluates and updates the materials. (n=7)
57.14
42.86
PPs5_5_4
Health promotion activities have goals, objectives & performance measures that are tracked & analyzed, and recommendations are made for program improvements. The number & type of health promotion activities are tracked & reported, including information on content, target audience, number of attendees. There is an evaluation process for health promotion efforts that is used to improve programs or revise curricula. (n=6)
83.33
16.67
PPs5_7_5
DOH staff members have training in health promotion methods as evidenced by training documentation. (n=6)
33.33
50.00
16.67
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
n = number of programs reviewed
demonstrates
partially demonstrates
does not demonstrate

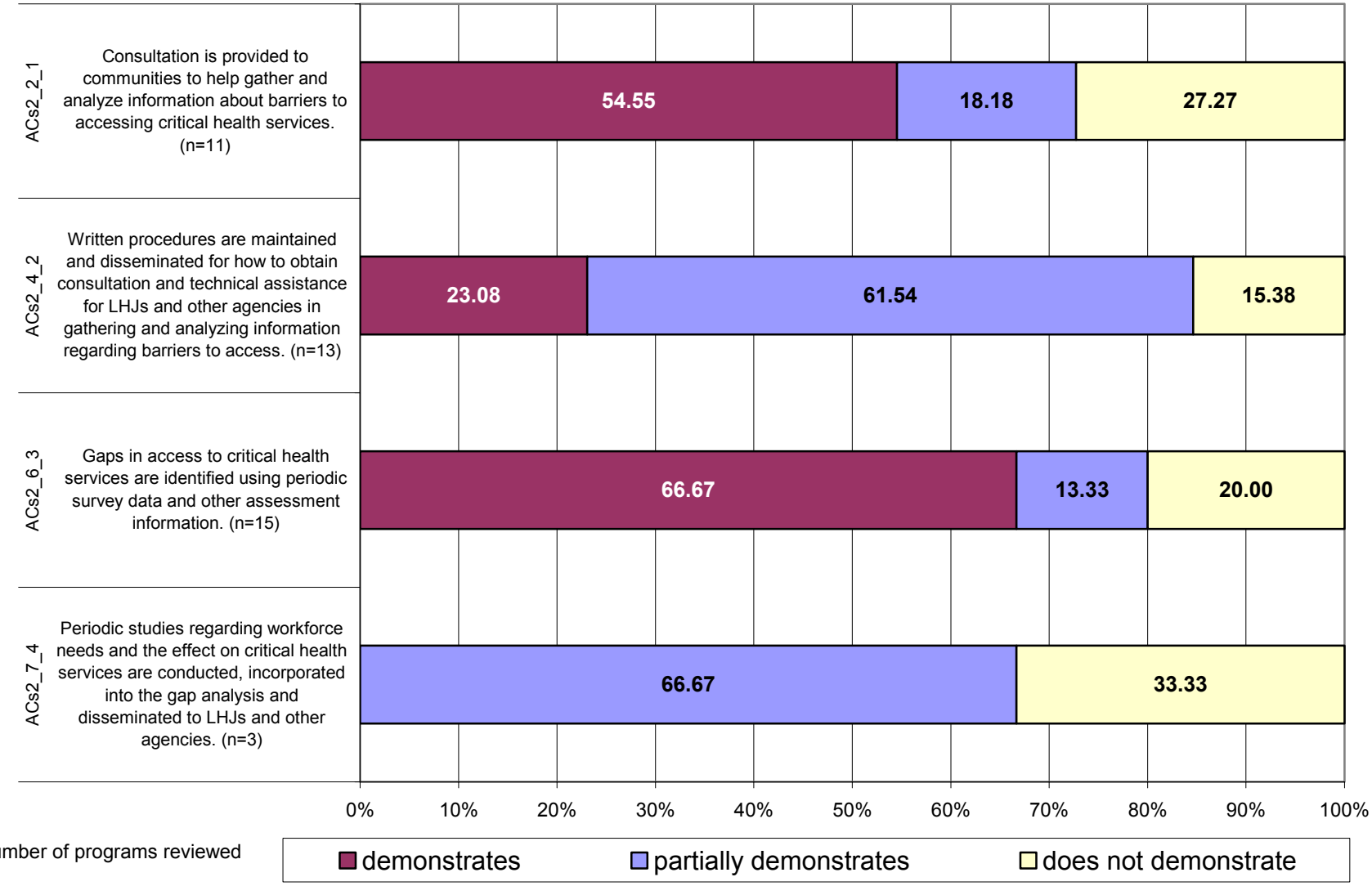
Chart 57: Helping People Get the Services They Need - DOH Programs, Standard 1



n = number of programs reviewed

demonstrates | partially demonstrates | does not demonstrate

Chart 58: Helping People Get the Services They Need - DOH Programs, Standard 2



n = number of programs reviewed

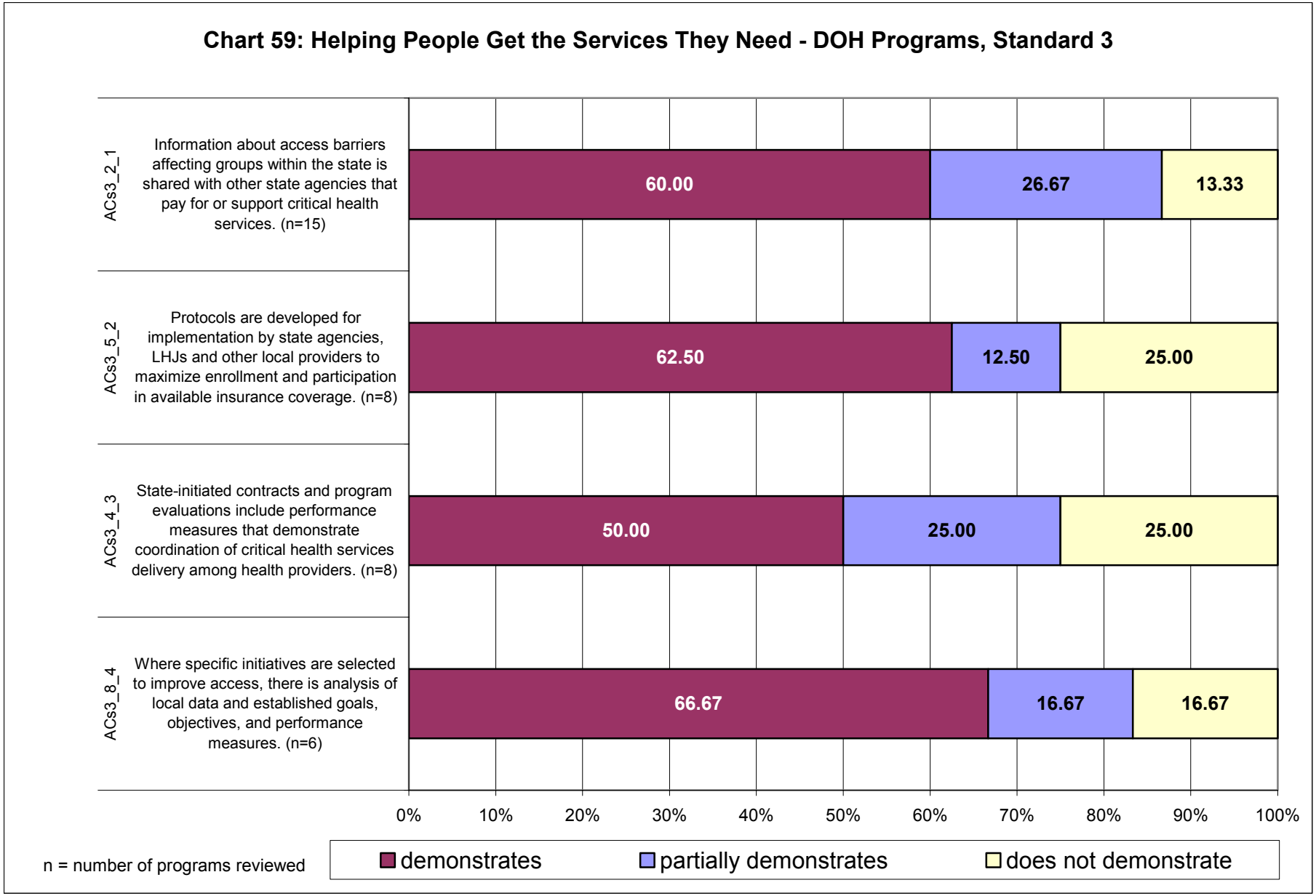


Chart 59: Helping People Get the Services They Need - DOH Programs, Standard 3
ACs3_2_1
Information about access barriers affecting groups within the state is shared with other state agencies that pay for or support critical health services. (n=15)
60.00
26.67
13.33
ACs3_5_2
Protocols are developed for implementation by state agencies, LHJs and other local providers to maximize enrollment and participation in available insurance coverage. (n=8)
62.50
12.50
25.00
ACs3_4_3
State-initiated contracts and program evaluations include performance measures that demonstrate coordination of critical health services delivery among health providers. (n=8)
50.00
25.00
25.00
ACs3_8_4
Where specific initiatives are selected to improve access, there is analysis of local data and established goals, objectives, and performance measures. (n=6)
66.67
16.67
16.67
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = number of programs reviewed
demonstrates
partially demonstrates
does not demonstrate

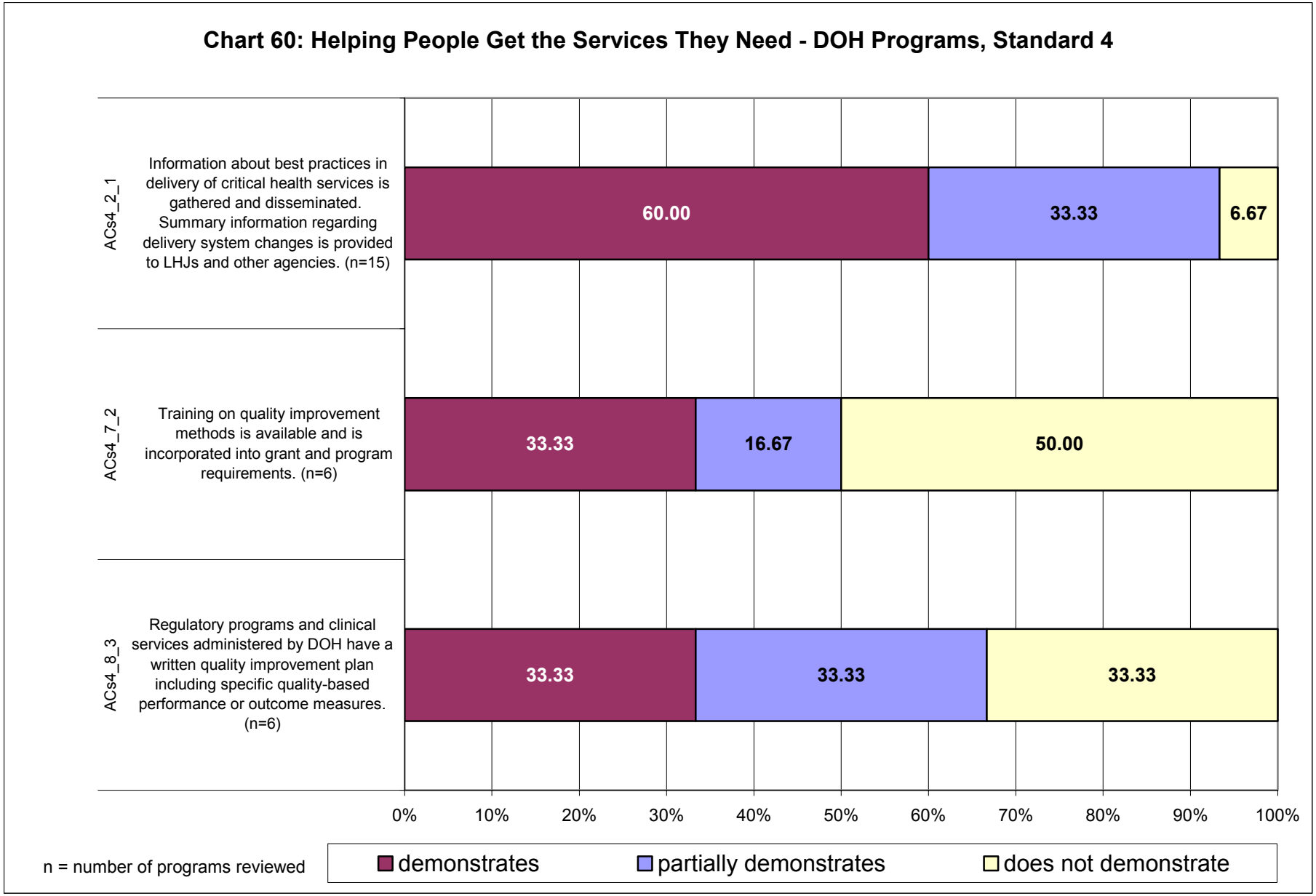


Chart 60: Helping People Get the Services They Need - DOH Programs, Standard 4
ACs4_2_1
Information about best practices in delivery of critical health services is gathered and disseminated. Summary information regarding delivery system changes is provided to LHJs and other agencies. (n=15)
60.00
33.33
6.67
ACs4_7_2
Training on quality improvement methods is available and is incorporated into grant and program requirements. (n=6)
33.33
16.67
50.00
ACs4_8_3
Regulatory programs and clinical services administered by DOH have a written quality improvement plan including specific quality-based performance or outcome measures. (n=6)
33.33
33.33
33.33
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = number of programs reviewed
demonstrates
partially demonstrates
does not demonstrate

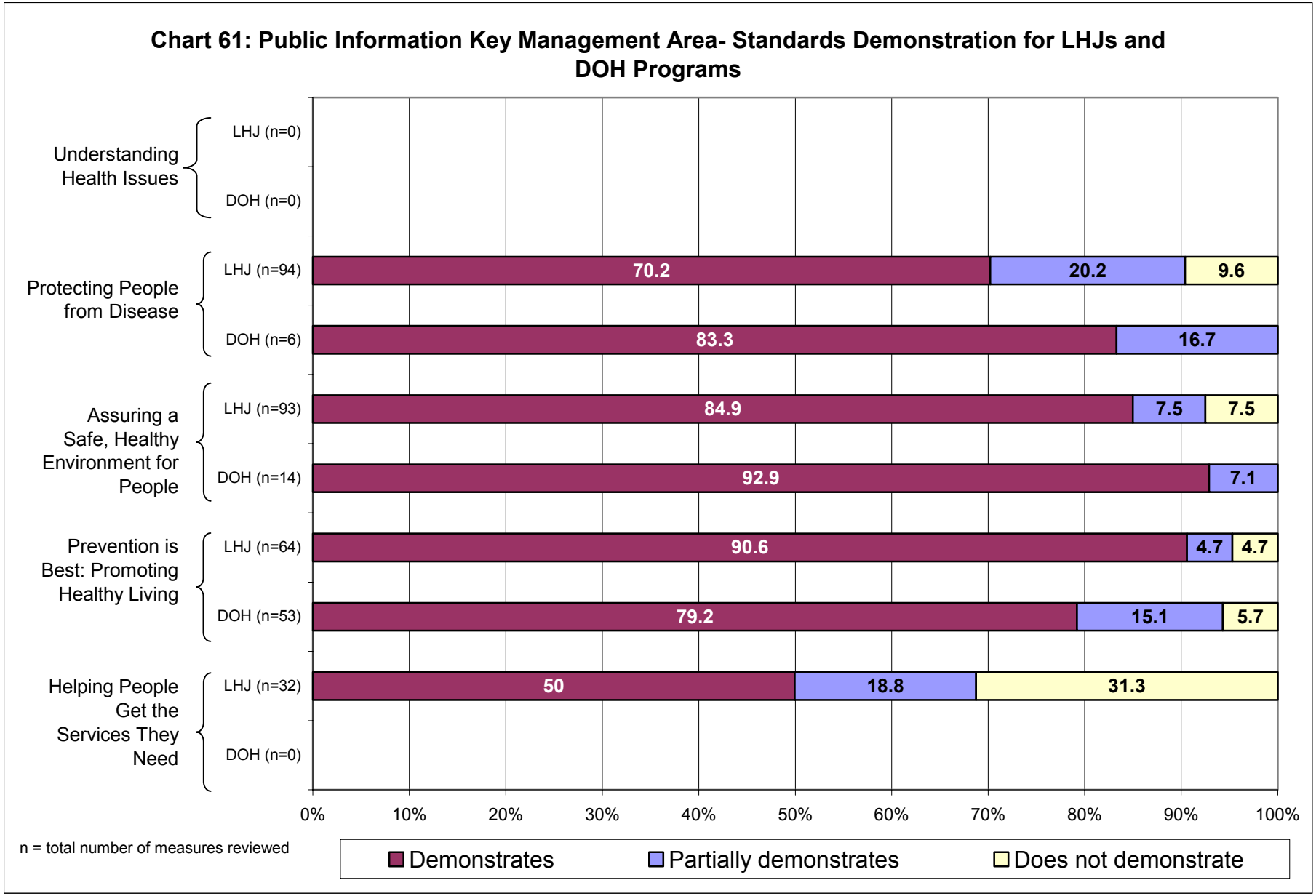


Chart 61: Public Information Key Management Area- Standards Demonstration for LHJs and DOH Programs
Understanding Health Issues
LHJ (n=0)
DOH (n=0)
Protecting People from Disease
LHJ (n=94)
70.2
20.2
9.6
DOH (n=6)
83.3
16.7
Assuring a Safe, Healthy Environment for People
LHJ (n=93)
84.9
7.5
7.5
DOH (n=14)
92.9
7.1
Prevention is Best: Promoting Healthy Living
LHJ (n=64)
90.6
4.7
4.7
DOH (n=53)
79.2
15.1
5.7
Helping People Get the Services They Need
LHJ (n=32)
50
18.8
31.3
DOH (n=0)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = total number of measures reviewed
Demonstrates
Partially demonstrates
Does not demonstrate

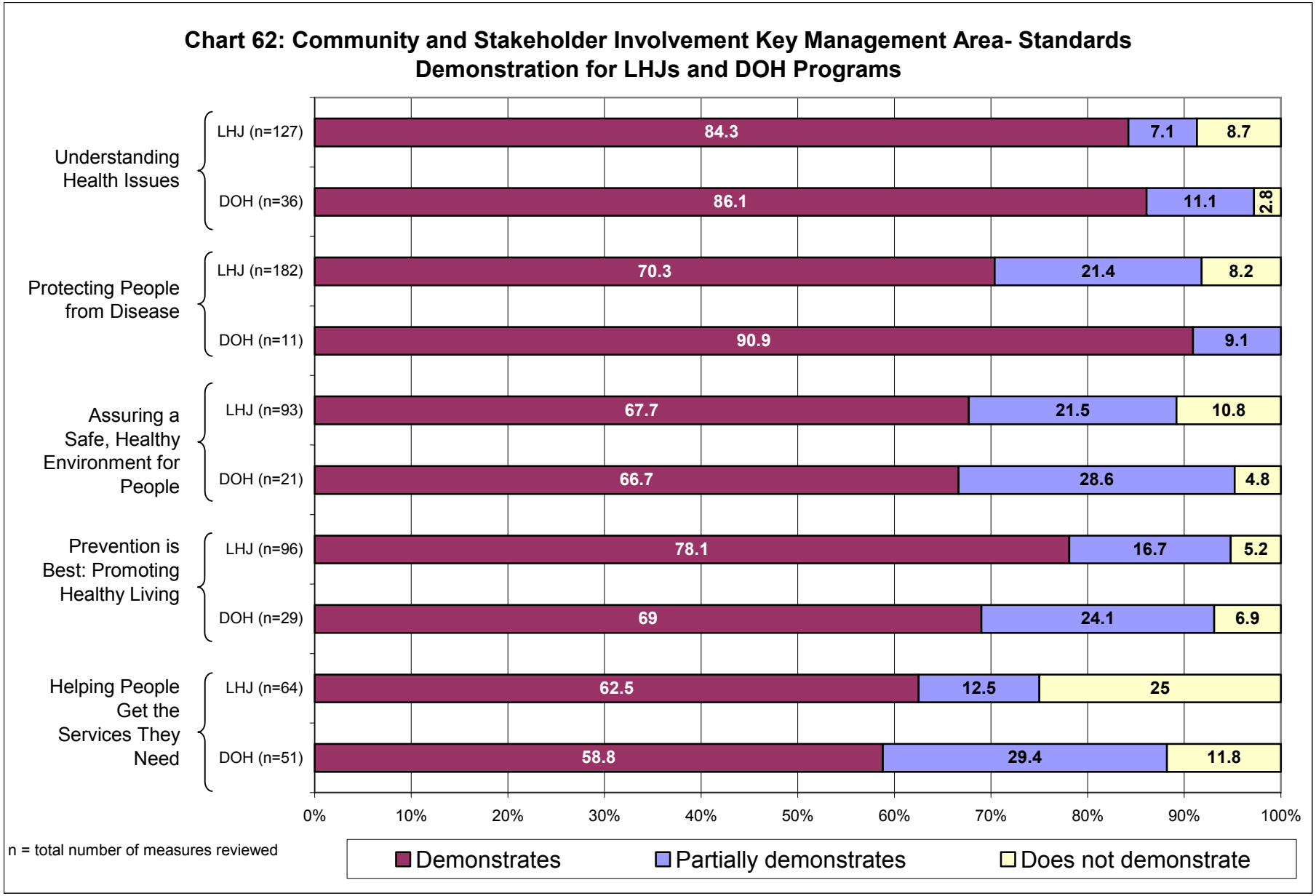


Chart 62: Community and Stakeholder Involvement Key Management Area- Standards Demonstration for LHJs and DOH Programs
Understanding Health Issues
LHJ (n=127)
84.3
7.1
8.7
DOH (n=36)
86.1
11.1
2.8
Protecting People from Disease
LHJ (n=182)
70.3
21.4
8.2
DOH (n=11)
90.9
9.1
Assuring a Safe, Healthy Environment for People
LHJ (n=93)
67.7
21.5
10.8
DOH (n=21)
66.7
28.6
4.8
Prevention is Best: Promoting Healthy Living
LHJ (n=96)
78.1
16.7
5.2
DOH (n=29)
69
24.1
6.9
Helping People Get the Services They Need
LHJ (n=64)
62.5
12.5
25
DOH (n=51)
58.8
29.4
11.8
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = total number of measures reviewed
Demonstrates
Partially demonstrates
Does not demonstrate

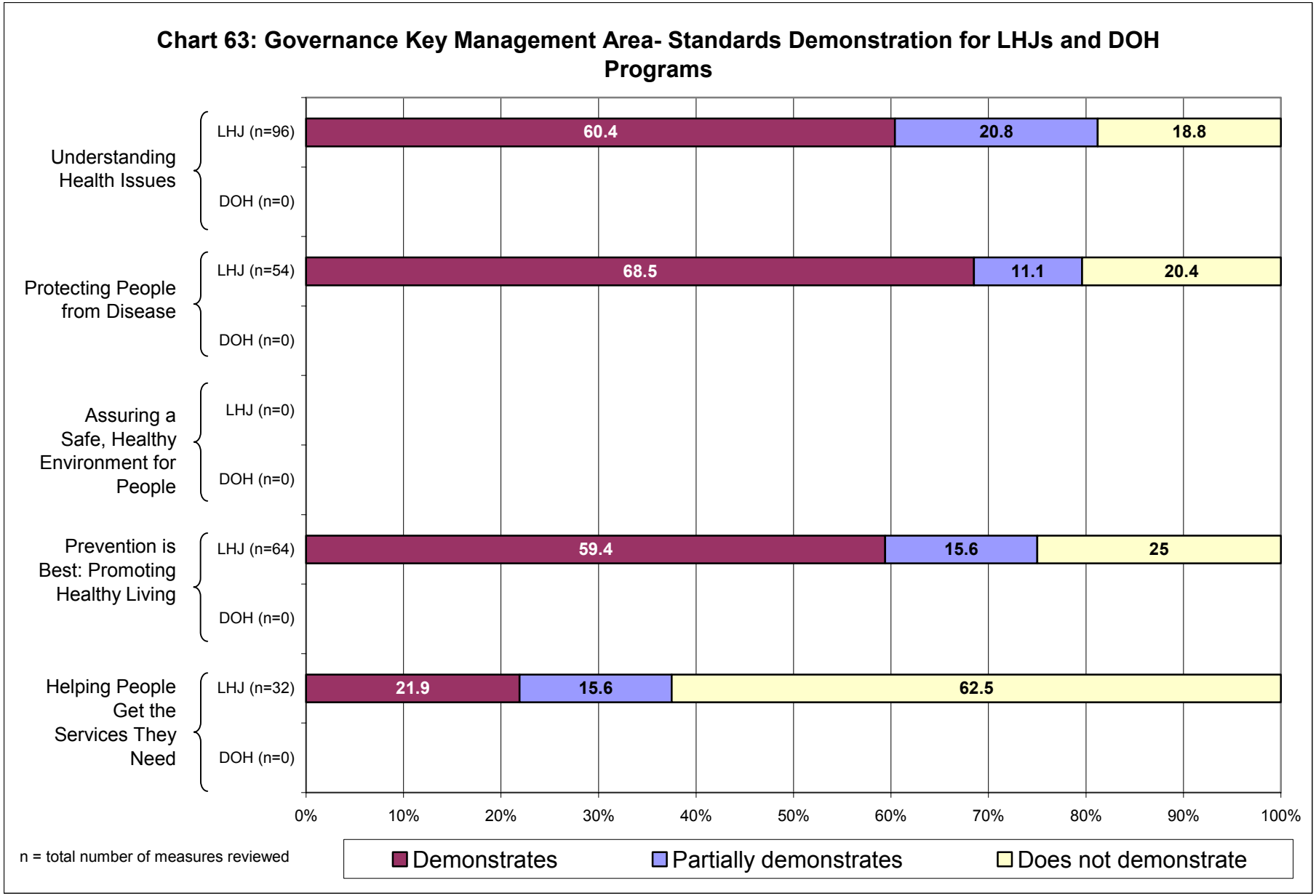


Chart 63: Governance Key Management Area- Standards Demonstration for LHJs and DOH Programs
Understanding Health Issues
LHJ (n=96)
60.4
20.8
18.8
DOH (n=0)
Protecting People from Disease
LHJ (n=54)
68.5
11.1
20.4
DOH (n=0)
Assuring a Safe, Healthy Environment for People
LHJ (n=0)
DOH (n=0)
Prevention is Best: Promoting Healthy Living
LHJ (n=64)
59.4
15.6
25
DOH (n=0)
Helping People Get the Services They Need
LHJ (n=32)
21.9
15.6
62.5
DOH (n=0)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = total number of measures reviewed
Demonstrates
Partially demonstrates
Does not demonstrate

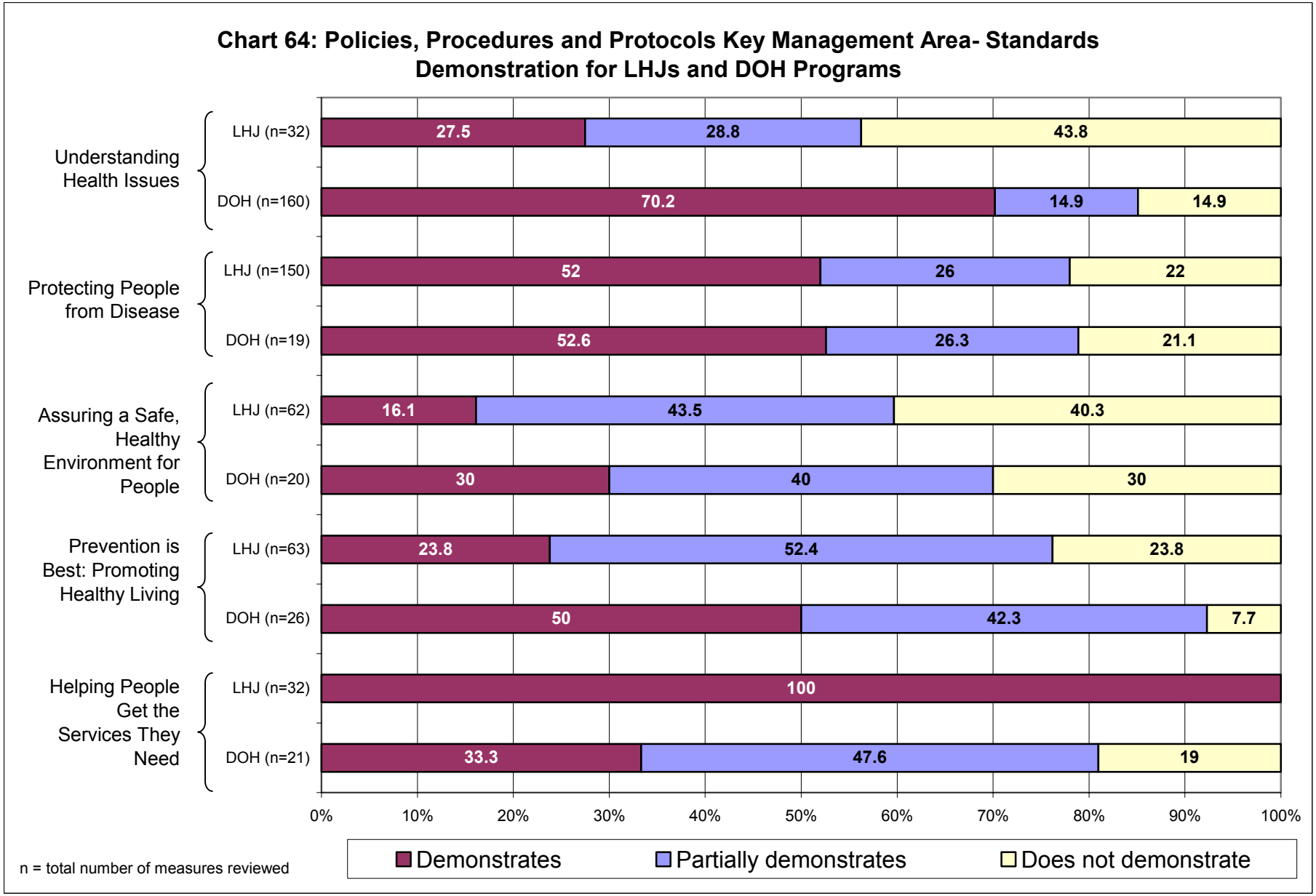


Chart 64: Policies, Procedures and Protocols Key Management Area- Standards Demonstration for LHJs and DOH Programs
Understanding Health Issues
LHJ (n=32)
27.5
28.8
43.8
DOH (n=160)
70.2
14.9
14.9
Protecting People from Disease
LHJ (n=150)
52
26
22
DOH (n=19)
52.6
26.3
21.1
Assuring a Safe, Healthy Environment for People
LHJ (n=62)
16.1
43.5
40.3
DOH (n=20)
30
40
30
Prevention is Best: Promoting Healthy Living
LHJ (n=63)
23.8
52.4
23.8
DOH (n=26)
50
42.3
7.7
Helping People Get the Services They Need
LHJ (n=32)
100
DOH (n=21)
33.3
47.6
19
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = total number of measures reviewed
Demonstrates
Partially demonstrates
Does not demonstrate

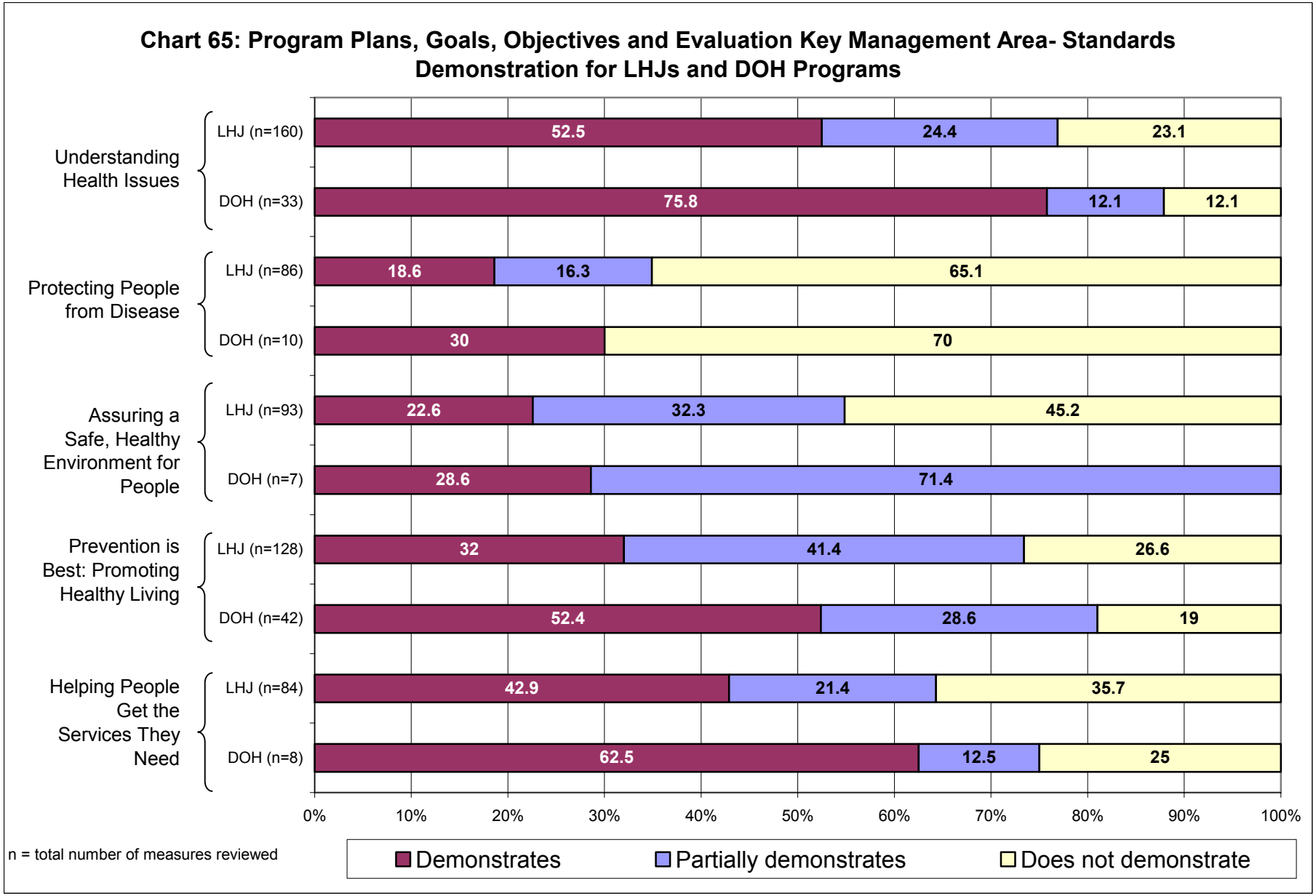


Chart 65: Program Plans, Goals, Objectives and Evaluation Key Management Area- Standards Demonstration for LHJs and DOH Programs
Understanding Health Issues
LHJ (n=160)
52.5
24.4
23.1
DOH (n=33)
75.8
12.1
12.1
Protecting People from Disease
LHJ (n=86)
18.6
16.3
65.1
DOH (n=10)
30
70
Assuring a Safe, Healthy Environment for People
LHJ (n=93)
22.6
32.3
45.2
DOH (n=7)
28.6
71.4
Prevention is Best: Promoting Healthy Living
LHJ (n=128)
32
41.4
26.6
DOH (n=42)
52.4
28.6
19
Helping People Get the Services They Need
LHJ (n=84)
42.9
21.4
35.7
DOH (n=8)
62.5
12.5
25
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = total number of measures reviewed
Demonstrates
Partially demonstrates
Does not demonstrate

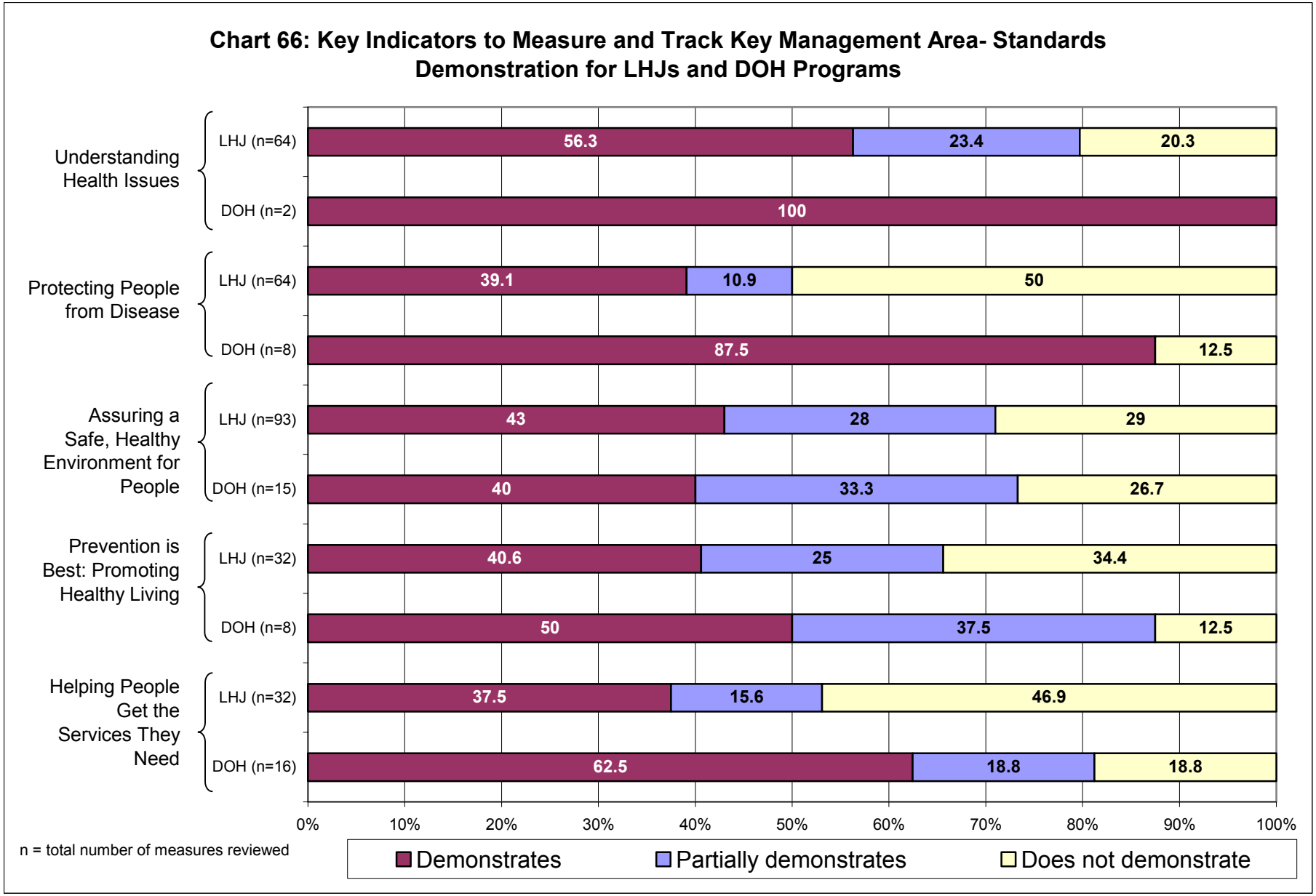


Chart 66: Key Indicators to Measure and Track Key Management Area- Standards Demonstration for LHJs and DOH Programs
Understanding Health Issues
LHJ (n=64)
56.3
23.4
20.3
DOH (n=2)
100
Protecting People from Disease
LHJ (n=64)
39.1
10.9
50
DOH (n=8)
87.5
12.5
Assuring a Safe, Healthy Environment for People
LHJ (n=93)
43
28
29
DOH (n=15)
40
33.3
26.7
Prevention is Best: Promoting Healthy Living
LHJ (n=32)
40.6
25
34.4
DOH (n=8)
50
37.5
12.5
Helping People Get the Services They Need
LHJ (n=32)
37.5
15.6
46.9
DOH (n=16)
62.5
18.8
18.8
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = total number of measures reviewed
Demonstrates
Partially demonstrates
Does not demonstrate

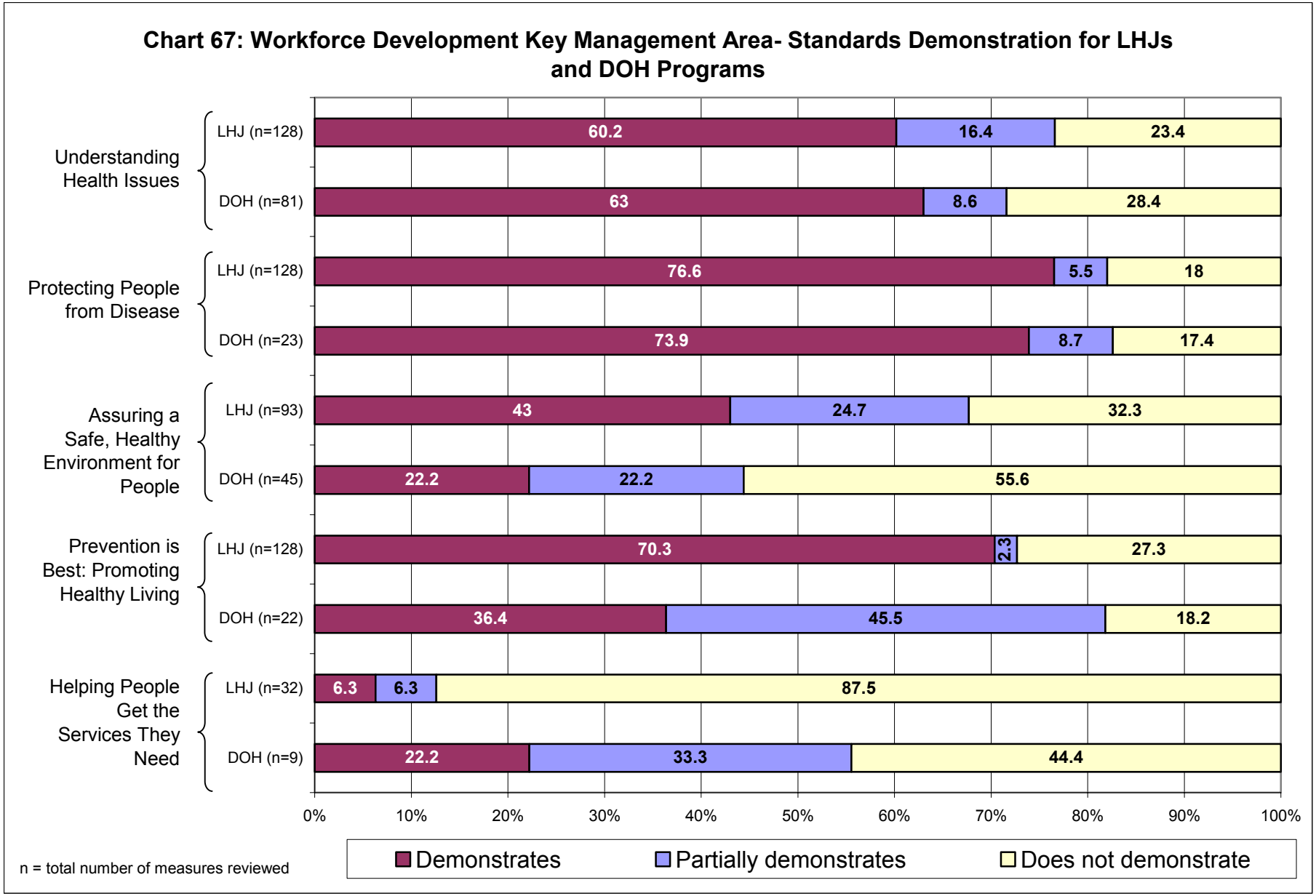


Chart 67: Workforce Development Key Management Area- Standards Demonstration for LHJs and DOH Programs
Understanding Health Issues
LHJ (n=128)
60.2
16.4
23.4
DOH (n=81)
63
8.6
28.4
Protecting People from Disease
LHJ (n=128)
76.6
5.5
18
DOH (n=23)
73.9
8.7
17.4
Assuring a Safe, Healthy Environment for People
LHJ (n=93)
43
24.7
32.3
DOH (n=45)
22.2
22.2
55.6
Prevention is Best: Promoting Healthy Living
LHJ (n=128)
70.3
2.3
27.3
DOH (n=22)
36.4
45.5
18.2
Helping People Get the Services They Need
LHJ (n=32)
6.3
6.3
87.5
DOH (n=9)
22.2
33.3
44.4
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = total number of measures reviewed
Demonstrates
Partially demonstrates
Does not demonstrate

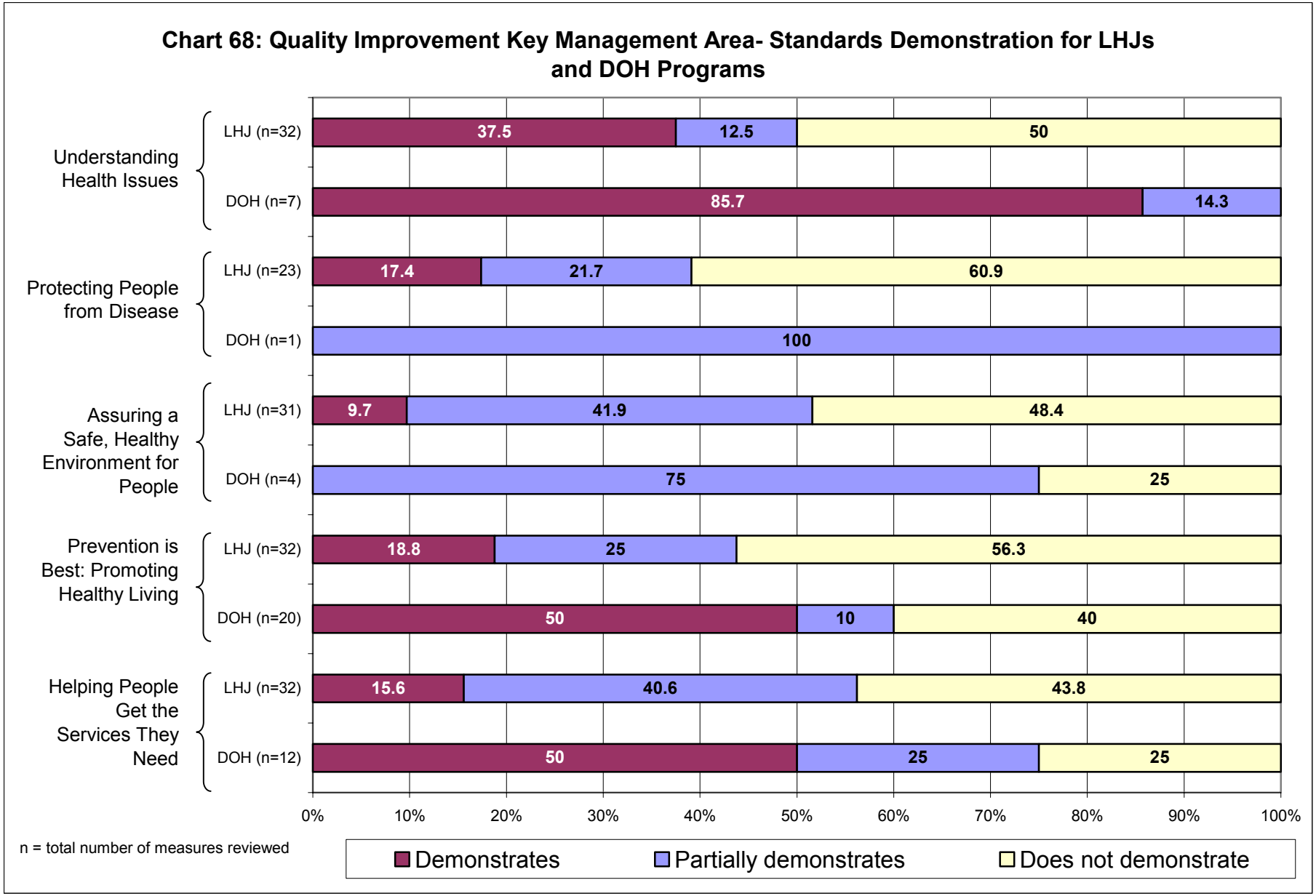


Chart 68: Quality Improvement Key Management Area- Standards Demonstration for LHJs and DOH Programs
Understanding Health Issues
LHJ (n=32)
37.5
12.5
50
DOH (n=7)
85.7
14.3
Protecting People from Disease
LHJ (n=23)
17.4
21.7
60.9
DOH (n=1)
100
Assuring a Safe, Healthy Environment for People
LHJ (n=31)
9.7
41.9
48.4
DOH (n=4)
75
25
Prevention is Best: Promoting Healthy Living
LHJ (n=32)
18.8
25
56.3
DOH (n=20)
50
10
40
Helping People Get the Services They Need
LHJ (n=32)
15.6
40.6
43.8
DOH (n=12)
50
25
25
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
n = total number of measures reviewed
Demonstrates
Partially demonstrates
Does not demonstrate

X. Attachment C: Peer Group Methodology and Summary Data

The follow material is excerpted from the Department of Health web site: http://www.doh.wa.gov/Data/Guidelines/RuralUrban.htm.

At the end of this excerpt there is a summary of how LHJs were grouped for the purposes of analysis in this report and a summary of the average topic area demonstration, by peer grouping.

Guidelines For Using Rural-Urban Classification Systems for Public Health Assessment

1. Purpose

The Assessment Operation Group in the Washington State Department of Health is coordinating the development of guidelines related to data development and use in order to promote good professional practice among staff involved in assessment activities within the Washington State Department of Health and in Local Health Jurisdictions in Washington. While the guidelines are intended for an audience of differing levels of training related to data development and use, they assume a basic knowledge of epidemiology and biostatistics. They are not intended to recreate basic texts and other sources of information related to the topics covered by the guidelines, but rather they focus on issues commonly encountered in public health practice and where applicable, to issues unique to Washington state.

2. Why a guideline on rural-urban classification systems?

A review of recent Washington state health data and research (Schueler and Stuart, 2000) found differences in health status between residents of rural and urban Washington. The unique challenges facing rural health care and health care systems are getting more attention. Analysts looking at rural health disparities must choose from several classification systems. Guidelines are useful for promoting consistency and comparability among analyses that look at rural health. Local public health assessments might also benefit from a classification system that can be used to compare local health data to areas with similar population and settlement patterns.

This is uncharted territory. According to two of the country's leading rural health researchers, Dr. Gary Hart at the University of Washington Rural Health Research Center and Dr. Thomas Ricketts at the Sheps Center at the University of North Carolina, no one has systematically addressed the question of how to best incorporate rural-urban classification systems into public health assessment.

3. What systems are commonly used to classify rural-urban character?

At least ten rural-urban classification systems are available for rural health assessment (Table 1). For detailed descriptions see A summary of major rural-urban classification systems.

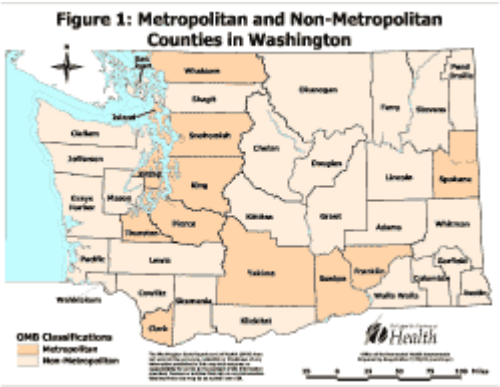
Table 1: Common Rural-Urban Classification Systems

Classification System	Developer	# of Classes	Geographic Unit	First Developed
Urban, Urbanized, and Rural Areas	US Bureau of the Census	2	Census Tract	1900 - 1920
Metropolitan and Non-Metropolitan	US Office of Management and Budget	2	County	1940s
Rural Urban Commuting Codes (RUCC)	US Department of Agriculture – Economic Research Service	10	County	1970s

(RUCC)	Research Service			
Goldsmith Modification to Metropolitan and Non-Metropolitan Codes	US Health Resources and Services Administration -Federal Office of Rural Health Policy	2	County with ZIP Code exceptions	Mid 1980s
Frontier, Remote, Less Remote and Urban	Washington Office of Community and Rural Health	4	County	Mid 1990s
Urban Influence Codes	US Department of Agriculture - Economic Research Service	9	County	Mid 1990s
Rural Urban Commuting Areas (RUCA)	US Health Resources and Services Administration - Federal Office of Rural Health Policy /US Department of Agriculture Economic Research Service	10	ZIP Code or Census Tract	Late 1990s
Metropolitan, Micropolitan, Outside Core-Based Statistical Area	US Office of Management and Budget	3	County	2000
Dominant RUCA County Codes	Washington Office of Community and Rural Health	5	County	2001
Four-Tiered Consolidation of RUCA codes	Washington Office of Community and Rural Health	4	ZIP Code or Census Tract	2001

4. Which is the best system for identifying rural areas in Washington?

Washington state presents unique challenges in classifying rural areas because of the range in the size of its counties. The most common classification systems (for example, Metropolitan vs. Non-Metropolitan) use county geography (Figure 1). County-based systems can misclassify some areas. The likelihood of misclassification increases with the size of the county. Nationally, 14 percent of residents of Metropolitan counties, as defined by the US Office of Management and Budget, are classified as rural by Bureau of Census definitions (Ricketts et al., 1998). An analysis of Behavioral Risk Factor Surveillance System (BRFSS) data in Washington found that using a ZIP code-based classification system uncovered differences that were not apparent when responses were classified with county-based systems (Schueler and Simmons, 2000). Sub-county definitions using ZIP code or census geography are preferable to county-based systems, because they provide greater discrimination between rural and urban areas.



Washington's rural areas are not homogenous. There are significant demographic differences between remote, small-town rural areas (such as Republic), large towns (such as Wenatchee),

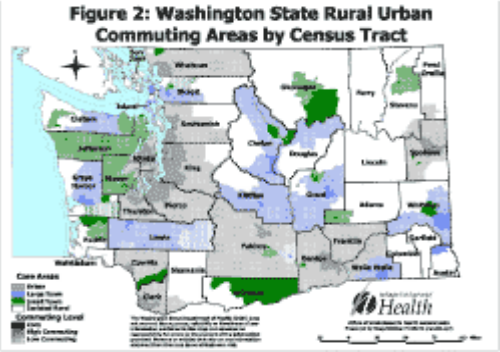
and urban fringe areas. A simple binary rural-urban classification can obscure important differences. However, the small populations in more remote rural areas often make it impractical to subdivide rural areas too finely. This is a particular concern for sample-based data such as BRFSS and for rare health events. The ideal system would differentiate among different types of rural areas, but should be collapsible into a smaller number of classifications if needed. For routine analyses, we recommend a three- to five- tiered system.

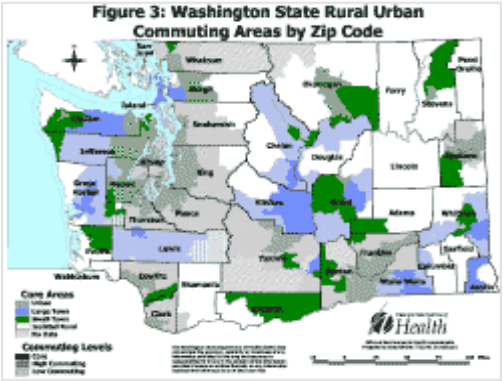
5. The Rural Urban Commuting Area (RUCA) system: a good choice

No systematic study or standards identify which definitions are most appropriate for analyzing specific types of public health data. The Office of Community and Rural Health recommends the Rural Urban Commuting Area (RUCA) system, because it is more flexible and precise than available alternatives.

The RUCA system is a ten-tiered classification system based on census tract geography. Both population size and commuting relationships are used to classify census tracts. First, urbanized (continuously built up areas of 50,000 or more), large town (10,000-49,999), and small town (2,500 to 9,999) cores areas are identified. Next, the primary (largest) and secondary (second largest) commuting flows of remaining tracts are examined using the most recently available commuting data. High commuting tracts are those where the primary or largest commuting flow is greater than 30% to a core area. Low commuting or influence area tracts are those where the largest flow to core areas is 5-30%.

The RUCA system provides a great deal of flexibility as the codes can be collapsed or combined in several different ways. Washington state RUCA codes using census tract geography are mapped in Figure 2. A ZIP code approximation is also available and is mapped in Figure 3. See Rural Urban Commuting Area Codes for a more detailed discussion of the system and information on where to obtain the codes.





6. Is the RUCA system the best fit in all situations?

Although the RUCA system is a good all around system, the analyst also should take into account how the classification system relates to the health phenomena being studied. Rural classification schemes are most commonly based on

- population density or clustering and/or
- degree of connection to or isolation from a urban core, as measured by commuting patterns or proximity to urban areas.

These approaches measure different population characteristics. For example, the prevalence of AIDS is closely linked to population centers. In studying AIDS migration to rural areas, rural classification systems that identify population clusters (including small and large town cores) are most appropriate and likely to identify changes over time. For health analyses where incidence may be tied to access to treatment, definitions using proximity or degree of connection to urban core areas are more appropriate. In this second case, it may be best to use county Urban Influence Codes or a combination of RUCA codes that emphasizes commuting relationships.

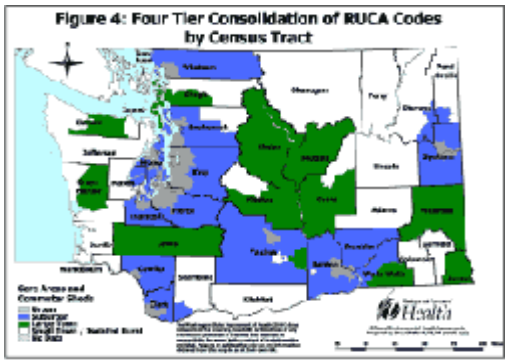
7. A suggested four-tiered consolidation of the RUCA system at the sub-county level

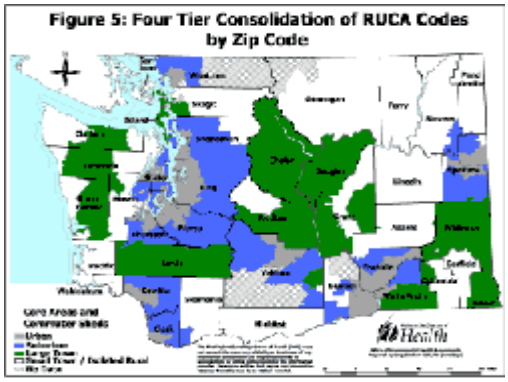
Many data sets will not support analysis using a ten-tiered classification system. The RUCA system can be collapsed in several ways. For general analyses of sub-county data, we suggest a four-tiered system.

- Urban Core Areas - continuously built up areas 50,000 persons or more. These areas correspond to US Bureau of the Census defined Urbanized Areas.
- Suburban Areas - areas with high commuting relationships with Urban Core Areas. Suburban areas include Large Town, Small Town and Isolated Rural Areas with high commuting levels to Urban Core Areas.
- Large Town Areas - towns with populations between 10,000 and 49,999 and surrounding rural areas with high commuting levels to these towns.
- Small Town and Isolated Rural Areas - towns with populations below 10,000 and their

commuter sheds and other isolated rural areas.

The census tract version (Figure 4) is slightly more precise than the ZIP code version (Figure 5), but the ZIP code version is readily used with a greater number of public health data sets. The specifications for this consolidation are found in Table 3.

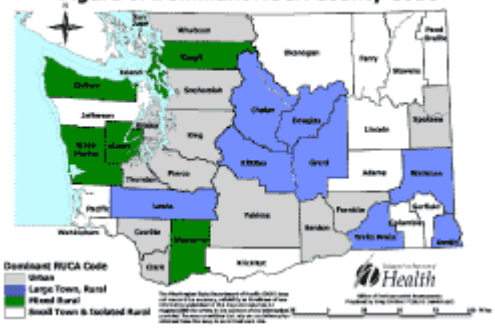




8. Is there a county-based version of RUCA codes?

The RUCA system was expressly developed at the census tract level to solve misclassification problems with county-based systems. In some cases, data may only be available at the county level. The Office of Community and Rural Health has developed a classification system based on the percentage of total county population residing in specific RUCA codes. There are five possible classes: Urban Dominated counties (includes Urban Core Areas and Suburban Areas), Large Town Dominated counties, Small Town/Isolated Rural Dominated counties, and two classes of counties with a mix of urban or rural characteristics. The rules for assigning dominant RUCA codes to counties are found in Table 4. Dominant RUCA codes by county are mapped in Figure 6 and listed in Table 5.

Figure 6: Dominant RUCA County Code



9. How will the 2000 Census affect RUCA classifications?

Most rural-urban classification systems rely on 1990 census data for population counts and commuting information to establish adjacency. Areas that have grown rapidly in the last decade may be misclassified. The greatest opportunity for misclassification is on the urban/rural fringe and between the urban and large town classifications. Rural-urban classification systems will be updated when the 2000 census data on commuting behavior become available in 2002. The US Bureau of the Census anticipates updated RUCA codes will be available by fall 2002.

10. Other considerations when making rural-urban comparisons

All population-based health indicators comparing urban and rural areas should be age-adjusted, as the proportion of elderly residents in rural areas is higher than in urban areas. (See Rates guideline.) Analysts should also keep in mind that, in general, the residents of rural Washington have lower incomes and have completed fewer years of formal education than those in other areas. Differences in health status between rural and urban Washingtonians may reflect underlying differences in demographics.

11. Guidelines: A recap

- If data are available at the census tract or ZIP code level, use the RUCA system.
- All rural-urban classification systems currently depend on 1990 commuting data. Updated codes are not likely to be available until fall 2002. Until the updated codes are released, the potential for misclassification should be noted in technical notes.
- For routine analyses we suggest collapsing the ten RUCA codes into four categories,
    - Urban Core Areas
    - Suburban Areas
    - Large Town Areas
    - Small Town and Isolated Rural Areas
- If data are only available at the county level, we recommend using the Office of Community and Rural Health's Dominant RUCA codes. The potential for misclassification should be discussed.
- Rural-urban differences may reflect underlying differences in demographics. In

general, rural-urban comparisons of health indicators should be age-adjusted, as the proportion of elderly residents in rural areas is higher than in urban areas. Analysts should also keep in mind that the residents of rural Washington have lower incomes and have completed fewer years of formal education than those in other areas.

- Document your choice of a rural-urban classification system and be sensitive to each system's limitations.

12. A summary of major rural-urban classification systems

This summary of rural classification methods draws heavily on Definitions of Rural: A Handbook for Health Policy Makers and Researchers (Ricketts et al., 1998), which is available at http://www.schsr.unc.edu/research_programs/Rural_Program/ruralit.pdf.

Urban, Urbanized, and Rural Areas: The US Bureau of the Census maintains definitions of Urban, Urbanized, and Rural Areas for classifying populations. Urban populations are those residing in incorporated areas or Census Designated Places with 2,500 or more or an Urbanized Area. An Urbanized Area (subset of Urban) is a continuously built up area of 50,000 people or more. A built up area is an area with a population density of more than 1,000 persons per square mile. This is calculated at the census block level. Rural populations are all those not classified as Urban or Urbanized. The definition of Urban population is overly inclusive because it includes very small towns. The definition for Urbanized is not inclusive enough. Areas with a population density of 999 persons per square mile are considered Rural. See http://www.census.gov/population/censusdata/urdef.txt for a detailed definition. The US Bureau of the Census expects that updated definitions based on 2000 census data will be available in fall 2002.

Metropolitan and Non-Metropolitan: The US Office of Management and Budget (OMB) has maintained this national classification system since the 1940s. The federal government uses this system extensively for statistical reporting and allocating funds. In this system, counties with cities or urbanized areas over 50,000 are classified as Metropolitan. Outlying counties meeting a complex set of conditions based on commuting patterns and population density are also designated Metropolitan. All other areas are designated Non-Metropolitan. Non-Metropolitan counties are not differentiated. The low commuting thresholds (in some cases 15%) used to tie outlying counties to core Metropolitan counties result in some counterintuitive classifications. For example, in Washington state, Island county is classified as a Metropolitan county because of commuting patterns from southern Whidbey Island and Camano Island. See Table 5 for the current list and Figure 1 for a map of Metropolitan and Non-Metropolitan counties in Washington. OMB revised this standard in December 2000. The new standard classifies counties as Metropolitan, Micropolitan and Outside Core-Based Statistical Areas.

Rural-Urban Continuum Codes (RUCC): The US Department of Agriculture's Economic Research Service developed the RUCC system, also known as the Beale code system, in the mid-1970s. The system uses OMB's Metropolitan and Non-Metropolitan classifications as a starting point. Metropolitan counties are classified into four population categories. Non-Metropolitan counties are classified into six categories on the basis of total population in US

Bureau of Census defined Urbanized Areas. Non-Metropolitan communities are further classified by adjacency to Metropolitan counties. Adjacent counties must be physically adjacent to a Metropolitan county and have at least 2% of the resident labor force commuting to a central Metropolitan county. This system better differentiates between central and fringe metropolitan areas. RUCC's have not been developed at the sub-county level as US Bureau of Census Urbanized Areas definitions are not readily transferable to census tract and ZIP code geography. The most recent update was in 1994 using 1990 census data. For more information see http://www.ers.usda.gov/briefing/rural/data/index.htm#Beale.

Goldsmith Modification to OMB Metropolitan – Non-Metropolitan County System: The Federal Office of Rural Health Policy developed the Goldsmith Modification to OMB's Metropolitan and Non-Metropolitan system in the 1980s to target funding to isolated rural areas in large Metropolitan counties. The Goldsmith method has two steps. First, Metropolitan counties over 1,225 square miles are identified. Several criteria are applied within these counties to identify whether individual census tracts are isolated from large cities in the county. Because of the 1,225 square mile threshold, isolated areas in smaller Metropolitan counties, for example Whatcom county, are not identified. This method was last updated in 1980s. The US Federal Office of Rural Health Policy which developed this classification system has discontinued use of the Goldsmith Modification in May 2002 and no longer publishes or updates the list. It has been replace with the ZIP Code version of the RUCA system. For more information on the Goldsmith Modification contact Vince Schueler at vince.schueler@doh.wa.gov.

Frontier, Remote, Less Remote and Urban Counties: The Office of Community and Rural Health developed this classification system in the mid 1990s for the "Rural Health Data Book." The system is an amalgamation of three different approaches. Frontier counties include all counties with population density less than six persons per square mile. Remote counties are defined as not having population centers of more than 10,000 and the majority of the population is more than 30 minutes travel time from such population centers. Less Remote counties are all other Non-Metropolitan counties. Urban counties are all Metropolitan counties with the exception of Island county which was classified as Less Remote. This method has not been used outside of Washington state.

US Department of Agriculture (USDA) Urban Influence Codes: The USDA Economic Research Service developed this classification scheme in the mid-1990s to emphasize the tendency of economic systems to centralize around very large metropolitan counties. Metropolitan counties are classified as Large Metropolitan (population >= 1 million) or Small Metropolitan (population < 1 million). Non-Metropolitan counties are classified as whether or not they are adjacent to these Large or Small Metropolitan counties using the same definition as RUCC (link paragraph above). This method is most useful for looking at the structure of health care systems and whether care or outcomes may be related to the complexity of the medical community or threshold levels of institution size (Rickets et al., 1998). This scheme is only available at the county level. It was calculated in 1993 using 1990 census data. For more information see http://www.ers.usda.gov/briefing/rural/data/index.htm.

Rural Urban Commuting Area Codes: The RUCA system is a ten-tiered classification system based on census tract geography. Both population size and commuting relationships are used to classify census tracts. First urbanized (continuously built up areas of 50,000 or more), large town (10,000-49,999), and small town (2,500 to 9,999) core tracts are identified. Next, the primary (largest) and secondary (second largest) commuting flows of remaining tracts are examined using the most recently available commuting data. High commuting tracts are those where the primary or largest commuting flow is greater than 30% to a core area. Low commuting tracts are those where the largest flow to core areas is 5-30%. Isolated rural areas are those with no town greater than 2,500 where the primary commuting flow is local. This yields the following scheme:

Table 2: Full Rural Urban Commuting Area (RUCA) Classification System

General Classification	Core Area	High Commuting (more than 30%)	Low Commuting (Between 5-30%)
Urban (50,000 or more)	1	2	3
Large Town (10,000 - 49,999)	4	5	6
Small Town (2,500 - 9,999)	7	8	9
Isolated Rural (Under 2,500)	10		

The University of Washington's Rural Health Research Center and Geography Department have developed a ZIP code approximation. The ZIP code approximation and other related research and tools are available at http://www.fammed.washington.edu/wwamirhrc/.

This ten-tiered classification system was developed in the late 1990s and is rapidly gaining wide use. It is the only system available at the census tract or ZIP code level. For more details see http://www.ers.usda.gov/briefing/rural/ruca/rucc.htm.

Four-Tiered Consolidation of RUCA Codes: Many data sets will not support analysis using a ten-tiered classification system. The Washington state Office of Community and Rural Health developed a Four-Tiered Consolidation of RUCA codes in 2001 for general analyses of sub-county data.

- Urban Core Areas - continuously built up areas 50,000 persons or more. These areas correspond to US Bureau of the Census defined Urbanized Areas.
- Suburban Areas - areas with high commuting relationships with Urban Core Areas. Suburban areas also include Large Town, Small Town and Isolated Rural Areas with high commuting levels to Urban Core Areas.
- Large Town Areas - towns with populations between 10,000 and 49,999 and surrounding rural areas with high commuting levels to these towns.
- Small Town and Isolated Rural Areas - towns with populations below 10,000 and their commuter sheds and other isolated rural areas.

The census tract version (Figure 4) is slightly more precise than the ZIP code version (Figure 5), but the ZIP code version is readily used with a greater number of public health data sets.

Table 3: Four-Tiered Consolidation of RUCA Codes

Consolidation Class	RUCA Codes
Urban Core Areas	1
Suburban Areas	2, 3, 4.1, 7.1, 8.1, 10.1
Large Town Areas	4, 5 ,6 ,7.2, 8.2, 10.2
Small Town and Isolated Rural Areas	7.0, 7.3, 7.4, 8, 8.3, 8.4, 9, 9.1, 9.2, 10, 10.3, 10.4, 10.5

Dominant RUCA County Codes: For cases where sub-county data are not available, the Office of Community and Rural Health has classified counties by dominant RUCA codes. To do this, we aggregated the population of census tracts within counties by RUCA code. Counties are classified as predominantly Urban, Large Town, or Small Town Rural, using the following rules:

Table 4: Rules for Assigning Dominant RUCA Codes to Counties

Dominant RUCA Code	Percent County Population	Residing in Tracts with RUCA Codes
Dominant Urban	> 75%	1, 2, 3, 4.1, 7.1, 8.1,10.1
Mixed Urban	50 - 75%	1, 2, 3, 4.1, 7.1, 8.1,10.1
Dominant Large Town Rural	> 75%	4, 5, 6, 7.2, 8.2, 10.2
Dominant Small Town and Isolated Rural	> 75%	7.0, 7.3, 7.4, 8, 8.3, 8.4, 9, 9.1, 9.2, 10, 10.3, 10.4, 10.5
Mixed Rural	50 - 75%	Large Town and Small Town/Rural combined but not meeting Large Town and Small Town Rural Classifications

Counties with less than 75% of the population residing within Urban Core, Suburban RUCAs, Large Town, or Small Town and Isolated Rural RUCAs as defined in the Four-Tiered Consolidation of RUCA Codes system are classified as mixed counties. There are currently no Mixed Urban counties in Washington.

Metropolitan, Micropolitan and Outside Core-Based Statistical Areas: The US Office of Management and Budget posted a revision of the Metropolitan and Non-Metropolitan system in the Federal Register 12/27/00. The Office of Management and Budget will not implement the revised system until 2003. The revised Metropolitan standard has three tiers based on the number of persons residing in Urbanized Areas within a county.

- Metropolitan - Over 50,000
- Micropolitan - 10,000 to 49,999
- Outside a Core-Based Statistical Area (CBSA) - all other counties.

In addition, any county in which at least 50% of the population resides in an Urbanized Area will be designated as Metropolitan or Micropolitan. Any outlying county in which at least 25%

of the residents commute to a Metropolitan or Micropolitan area will be designated with the core area designation. Although the commuting thresholds used to tie in outlying counties are higher than those in the original classification system, in some cases, they are low enough so that some counties adjacent to Metropolitan counties with distinctly rural characteristics are included with Metropolitan counties. For example, Skamania county will be considered part of the Portland Metropolitan area, although there is no community over 1,200 residents in the county. Nonetheless, the 2000 revision is an improvement over the prior Metropolitan and Non-Metropolitan classification. For more information on existing and proposed definitions see http://www.census.gov/population/www/ estimates/masrp.html.

13. Other variations

Several other classification systems that apply to subsets of areas, activities, or populations may be useful for rural public health assessment. These include several competing definitions of frontier areas and county-based typologies of primary economic activity. See Ricketts et al. (1998) or the USDA Economic Research Service Website at http://www.ers.usda.gov/Briefing/ for more detail.

Table 5: Rural Urban Classifications for Washington Counties

County	Metropolitan Non-	Metropolitan		Dominant Rural	1999
Adams	Non-Metropolitan	Outside	Remote	Small Town/ Rural	15,128
Asotin	Non-Metropolitan	Micropolitan	Less Remote	Large Town	21,548
Benton	Metropolitan	Micropolitan	Urban	Urban	139,704
Chelan	Non-Metropolitan	Micropolitan	Less Remote	Large Town	61,453
Clallam	Non-Metropolitan	Micropolitan	Less Remote	Mixed Rural	64,854
Clark	Metropolitan	Micropolitan	Urban	Urban	322,984
Columbia	Non-Metropolitan	Outside	Frontier	Small Town/ Rural	4,358
Cowlitz	Non-Metropolitan	Metropolitan	Less Remote	Urban	91,618
Douglas	Non-Metropolitan	Micropolitan	Remote	Large Town	34,187
Ferry	Non-Metropolitan	Outside	Frontier	Small Town/ Rural	7,378
Franklin	Metropolitan	Metropolitan	Urban	Urban	47,195
Garfield	Non-Metropolitan	Outside	Frontier	Small Town/ Rural	2,312
Grant	Non-Metropolitan	Outside	Less Remote	Large Town	70,871
Grays Harbor	Non-Metropolitan	Micropolitan	Less Remote	Mixed Rural	68,615
Island	Metropolitan	Micropolitan	Less Remote	Mixed Rural	71,021
Jefferson	Non-Metropolitan	Outside	Remote	Small Town/ Rural	26,634
King	Metropolitan	Metropolitan	Urban	Urban	1,641,000
Kitsap	Metropolitan	Metropolitan	Urban	Urban	240,622
Kittitas	Non-Metropolitan	Micropolitan	Less Remote	Large Town	31,923
Klickitat	Non-Metropolitan	Outside	Remote	Small Town/ Rural	18,976
Lewis	Non-Metropolitan	Micropolitan	Less Remote	Large Town	68,588
Lincoln	Non-Metropolitan	Outside	Frontier	Small Town/ Rural	9,747
Mason	Non-Metropolitan	Outside	Less Remote	Mixed Rural	50,990
Okanogan	Non-Metropolitan	Outside	Remote	Small Town/ Rural	39,333

Okanogan	Non-Metropolitan	Outside	Remote	Small Town/ Rural	39,333
Pacific	Non-Metropolitan	Outside	Remote	Small Town/ Rural	21,588
Pend Oreille	Non-Metropolitan	Outside	Remote	Small Town/ Rural	11,766
Pierce	Metropolitan	Metropolitan	Urban	Urban	670,586
San Juan	Non-Metropolitan	Outside	Remote	Small Town/ Rural	12,518
Skagit	Non-Metropolitan	Micropolitan	Less Remote	Mixed Rural	99,066
Skamania	Non-Metropolitan	Metropolitan	Frontier	Mixed Rural	9,669
Snohomish	Metropolitan	Metropolitan	Urban	Urban	563,043
Spokane	Metropolitan	Metropolitan	Urban	Urban	412,671
Stevens	Non-Metropolitan	Outside	Remote	Small Town/ Rural	40,603
Thurston	Metropolitan	Metropolitan	Urban	Urban	204,980
Wahkiakum	Non-Metropolitan	Outside	Remote	Small Town/ Rural	3,888
Walla Walla	Non-Metropolitan	Micropolitan	Less Remote	Large Town	54,315
Whatcom	Metropolitan	Metropolitan	Urban	Urban	158,000
Whitman	Non-Metropolitan	Micropolitan	Less Remote	Large Town	39,589
Yakima	Metropolitan	Metropolitan	Urban	Urban	222,419

14. References

Ricketts TC, Johnson-Webb KD, Taylor P. Rural definitions for health policy makers. Bethesda (MD): Dept. of Health and Human Services (US), Federal Office of Rural Health Policy; 1998 July.

Schueler V, Stuart B. Recent research and data on rural health in Washington State. Olympia (WA): 2000 October.

Schueler V, Simmons K. Defining rural for public health assessment. Washington State Department of Health , Office of Community and Rural Health; 2000 October.

Peer Groups for Baseline Evaluation Analysis:

Small Town/Rural	Mixed Rural	Large Town	Urban
Adams	Clallam	Asotin	Benton/Franklin
Columbia	Grays Harbor	Chelan/Douglas	Cowlitz
Garfield	Island	Grant	King
Jefferson	Mason	Kittitas	Kitsap
Klickitat	Skagit	Lewis	Pierce
Lincoln		Walla Walla	Snohomish
NE Tri-County		Whitman	Spokane
Okanogan			SWWHD*
Pacific			Thurston
San Juan			Whatcom
Wahkiakum			Yakima

* at the time of the site review, included Skamania, which is classified as mixed rural

Peer Groups: Average Percent of Measures Demonstrated by Topic Area

	Small Town/Rural	Mixed Rural	Large Town	Urban
Understanding Health Issues				
Demonstrates	43%	47%	43%	75%
Partially Demonstrates	26%	20%	23%	14%
Does not Demonstrate	31%	33%	34%	12%
Protecting People from Disease				
Demonstrates	49%	52%	54%	70%
Partially Demonstrates	22%	15%	22%	13%
Does not Demonstrate	30%	33%	25%	17%
Assuring a Safe, Healthy Environment for People				
Demonstrates	40%	41%	43%	55%
Partially Demonstrates	20%	28%	29%	28%
Does not Demonstrate	40%	31%	29%	17%
Prevention is Best: Promoting Healthy Living				
Demonstrates	50%	47%	50%	67%
Partially Demonstrates	24%	19%	24%	21%
Does not Demonstrate	26%	34%	26%	12%
Helping People Get the Services They Need				
Demonstrates	35%	35%	36%	60%
Partially Demonstrates	24%	17%	11%	15%
Does not Demonstrate	41%	48%	53%	25%

XI. Attachment D: Discussion Paper

Performance Standards in Public Health Systems: The Standards for Public Health in Washington State

September 9, 2002

Prepared by
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Marlene Mason
MCPP Healthcare Consulting
for the
Standards Committee
Public Health Improvement Partnership

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Background

Public Health in the US has been measuring its performance for over 80 years. This evaluation has shifted back and forth between "doing things right" (counting visits and inspections and immunizations) and "doing the right things" (taking action on the analysis of community health assessments). Increasingly, the public health systems have moved toward the "doing the right things" end of the continuum – that is measuring results as well as measuring resources and activities. In other words, measuring outcomes rather than just counting inputs and outputs. (1)

In 1993, Washington State responded to the growing movement to measure public health as a system in order to improve overall public health protection and to identify exemplary practices. The Washington legislature enacted legislation to establish minimum public health standards and the State's Public Health Improvement Plan (PHIP). In 1995 the Washington State legislature accepted the first PHIP and required performance- based contracts. By 1998 the PHIP contained a model of Standards for Public Health, using a framework of single performance standards for all parts of the state's public health system, with unique local and state level measures to address the different responsibilities at state and local levels. After two intensive field tests of the standards and the measures themselves, the Standards Committee of the PHIP initiated the Baseline Evaluation of Public Health Performance Standards Project in the Spring of 2002.

The Standards for Public Health in Washington State exemplify the national goals for public health performance measurement and development of standards—quality improvement, accountability, and science. The purpose of this article is to describe the relationship of the Standards for Public Health in Washington State to the framework of performance measurement approaches that have emerged for healthcare and public health organizations nationally.

Defining Performance Measurement

To gain an overall perspective on measuring performance it is necessary to first understand what we mean when we use measurement language. The *Guidebook for Performance Measurement* produced in December 1999 by the Turning Point Project, a national collaborative of public health agencies, provides standard definitions of terms. According to the *Guidebook:*

- *Performance measurement* is the "regular collection and reporting of data to track work produced and results achieved";
- *Performance measure* is "the specific quantitative representation of capacity, process, or outcome deemed relevant to the assessment of performance";
- *Performance standard* is " a generally accepted, objective standard of measurement such as a rule or guideline against which an organization's level of performance can be compared";
- *Performance management* is "the use of performance measurement information to help set agreed-upon performance goals, allocate and prioritize resources, inform managers to either confirm or change current policy or program directions to meet those goals, and report on the success in meeting those goals"; and,
- *Performance measurement is "NOT punishment"*. (2)

Essentially, performance measurement analyzes the success of an organization's efforts by comparing data on what actually happened to what was planned or intended. (3)

> *Performance measurement is not something done to you by someone else but something done together, in partnership, to improve your ability at every level – local, state, regional, and national – to achieve your common goals.*
>
> *Former Assistant Secretary for Health, Philip R. Lee*
> *(Guidebook for Performance Measurement)*

Range of Approaches to Measuring the Performance of Systems

Audits and Individual Program Evaluation

Audits for evaluating public health programs or healthcare providers have been used in healthcare for decades and have become more sophisticated over time. Audits have been the standard practice for determining whether contract or regulatory requirements were being met. These audits resulted in a listing of deficiencies, requirements for corrective action, and either a renewal or denial of contracts or licenses.

Program evaluation requirements have been used in the last couple of decades to assess the extent to which programs are meeting goals and objectives, especially in regard to the effective use of public funds. In September of 1999 the Centers for Disease Control (CDC) released the *Framework for Program Evaluation in Public Health.* The framework was developed by a committee of public health and measurement experts to facilitate the integration of program evaluation throughout the public health system. The framework is a practical, non-prescriptive tool with six general steps for evaluating individual program performance. Program evaluations and audits are important to assessing the extent that a program meets its individual requirements. Effectively performing program evaluations is a necessary part of overall system performance measurement.

An audit or individual program evaluation approach, however, is not effective in measuring the performance of large, multi-disciplinary organizations like hospitals, provider organizations, health plans and public health systems. As hospitals and other residential facilities began merging with outpatient care organizations and with physician groups to form large healthcare delivery systems and as public health expanded the scope of services provided, it became clear that it would be impossible to improve the larger system with program level data. To look at every aspect of these large systems would be too burdensome and costly. Audits, due to their focus on single programs or projects, do not result in consistent system-wide information that will support improvement in system performance. For these purposes an accreditation or certification approach emerged as the most appropriate approach for evaluating the performance of large systems.

Accreditation or Certification Evaluations

New approaches for evaluating the performance of larger organizational systems were developed, based on agreed-upon performance standards, by entities such as the National Committee for Quality Assurance (NCQA), HCFA (now Centers for Medicare & Medicaid Services [CMS]) and others. The Joint Commission on Accreditation of Hospitals (JCAH) incorporated new standards for these larger, integrated care delivery systems and became JCAHO, the Joint Commission on the Accreditation of Healthcare Organizations. In contrast to

contractual or regulatory audits, accreditation or certification may not be required for health organizations to continue operations (although it may be required as the basis for contracting with some payors). It is an additional, valuable indication of the quality of the care and service provided by the health system.

These accreditation entities differ from traditional auditing entities in their approach to measuring the performance of the system, and in the results of the evaluation. Accreditation entities still encompass a wide range of approaches to evaluating performance, but have some common factors. External accreditation entities are hired by the subject organizations to evaluate the overall performance of the system and to confer a level of performance against the standards. There are usually no "corrective actions" required by accreditation organizations although JCAHO does make recommendations for improvement and does require progress reports on these issues in order for the organization to maintain JCAHO accreditation. All accreditation entities deliver comprehensive performance reports to the organization and confer independent accreditation status to the organization.

Stretch Standards

Because the results of accreditation system evaluations are primarily for improving the performance of the system, the performance standards do not describe the system exactly as it is performing at the current time. The standards articulate a higher level of performance, often described as "stretch" standards. It is important that the standards and measures are not all immediately attainable by all parts of the system. Stretch standards and measures also provide a more stable measurement tool that yield comparable results over the course of several evaluation cycles.

> ***Developing a model to predict and describe public health capacity is not the primary purpose of the performance standards process. Existing survey instruments already accomplish this purpose. Instead, the performance standards tools should provide a road map that can be used by public health organizations to establish measurable goals and objectives for system improvement."***
>
> **Paul K. Halverson**
> **Public Health Management and Practice, September 2000**

Evaluation of Selected Components

Accreditation evaluations also differ from traditional audits in that they do not evaluate all units or programs for each of the identified standards. For example, NCQA has a standard that addresses health management programs. While a health plan being reviewed by NCQA may, in fact, conduct 6 or 7 different health management programs, NCQA surveyors evaluate two selected programs for their performance against the standards. Similarly, during a JCAHO survey, the reviewers may review only half or two-thirds of the organization's practitioner sites to evaluate the overall practitioner site performance against the applicable JCAHO standards. When accreditation status is awarded, there is no distinction made regarding the number of program and/or site reviews in one organization compared to another, leading to the accreditation—comparability is assumed.

Type or Scope of Review

Another important concept used in accreditation processes is the extent of the review for each measure. The most common type of review is called a "SAMPLE". For sample review measures, only some of the components or programs are evaluated against the measure. For some measures the reviewers may be required to evaluate every component selected for the evaluation against that measure. This type of review is called "ALL". The final type of review is the measure that can be evaluated once for the entire organization and is called a "ONCE" type of review.

Evidence of Application of an Improvement Cycle

Accreditation-type standards and measures often reflect an improvement cycle such as Plan-Do-Check-Act (PDCA) for each topic that they address. For example, the NCQA standards and measures for clinical guidelines include requirements for evidenced-based clinical practice guidelines (CPGs). These CPGs are the *plan* step of the cycle. The next measure requires the distribution of the CPG to providers (the *do* step), then the measurement of provider compliance with the guideline (the *check* step), and the review and updating of the CPGs (the *act* step). This application of the improvement cycle in the standards and measures themselves is a unique and critical part of accreditation and certification programs.

> ***A performance standards system therefore is not simply a report card for public health organizations. Rather, performance standards are tools that public health professionals can use to build infrastructure by informing ourselves, our policy makers, and our constituents about the strengths and weaknesses in our systems.***
>
> **Paul K. Halverson, Editorial**
> **Public Health Management and Practice, September 2000**

Quality Award Evaluation

Another approach to performance evaluation is the quality award system represented by the Baldrige Criteria for Performance Excellence. The Baldrige process of evaluation, developed in the late 1980s, uses an external team consensus model to determine how systematic the organization's approach to the evaluation item is and the extent of deployment of that approach in six categories of criteria. The seventh category is the evaluation of the results achieved by the organization. An organization applies to be evaluated for a Baldrige Quality Award and only the organizations that achieve high performance against the criteria receive an award. All other applicants simply receive a written report. What the organization does with the written results is completely up to the leadership of the organization. Most importantly, there is no information that tells any outside entity how the organization performed, or how that might be related to the performance of similar organizations. The award winning organization must communicate any and all information about their operations and outcomes themselves. In order for people from another organization to build upon the achievements of the award winner, they must conduct a site visit to understand the award winner's work processes and strategies for success.

Other differences among these performance measurement approaches are described below.

	Regulatory or contractual audits	*Program Evaluation*	*Accreditation or Certification processes*	*Quality Award*
Purpose	To meet requirements in order to continue contract, comply with regulations, or to renew license	To assess the program's effectiveness in meeting established goals and/or objectives	To demonstrate the quality of system or of the care and services by achieving high level of accreditation	To demonstrate high quality across the organization's systems to receive quality award
Evaluation entity	Individual program or specific component of larger organization	Specific program within an organization	Numerous, selected programs or components representing the entire organization	All components of major division or entire organization
Who chooses entities and timing of evaluation	Regulator or contractor determines scope and timing of evaluation	Oversight entity or the program leadership	Organization determines scope and timing of evaluation	Organization applies for review to be considered for award
Evaluation system	Auditors determine compliance against contract requirements, laws or regulations	Evaluators determine extent to which program is meeting goals and objectives, ideally related to service outcomes	Surveyors evaluate performance against a set of standards and measures developed through multi-disciplinary process	Team of examiners reaches consensus on performance against a set of established criteria
Results	Written report with list of deficiencies and required corrective actions	Written report, often annual or more frequent, with summary of findings and extent that goals and objectives are being achieved	Level of performance on standards and accreditation status. No follow-up, but accreditation can be denied. All receive written report.	Only organizations that achieve a high level of performance receive award. All receive written report
Uses of results	Corrective Action Plan (CAP), and determination of continuation of contracts	Actions for improvement to address goals and objectives that are not being met	Improvement of system's processes and outcomes. Establishment of exemplary or best practices.	Award winners

Uses of Accreditation and Other Evaluation Results

Two of the primary uses for results of program evaluations, accreditation or quality awards are for (1) *making comparisons* of performance levels and (2) *improving the quality* of the processes and outcomes of the organization.

For *comparison* purposes, the standards and measures should provide sufficiently valid and reliable quantification such that comparison across the system's programs and departments can be made. By identifying the highest level of performance or outcome (the benchmark), an organization can duplicate those work processes to achieve higher performance overall.

For *improving quality*, some standards and measures lend themselves more to internal monitoring of performance and local accountability and are most suitable for supporting the improvement of the organization rather than for comparability among organizations.

The American College of Mental Health Administration (ACMHA) has applied these distinctions between *comparison* and *quality improvement* in a proposed *Consensus Set of Indicators for Behavioral Health***.** In this project, five national accreditation entities (CARF [The Rehabilitation Commission], the Council on Accreditation, the Council on Quality and Leadership in Support of Persons with Disabilities, JCAHO and NCQA) reached consensus on a set of performance measures. They concluded that it was "important to recognize that selecting appropriate measures depends on the purpose of assessing performance. For example, one purpose would be for determining quality improvement needed and another purpose is to hold providers accountable for the care being given." They have designated measures as either a comparison measure or a quality improvement measure to clarify the intended use of each measure and its data set.

Application to Public Health Nationally

In 1997 the CDC established the Public Health Practice Program Office (PHPPO) to address the initiative to advance the capacity of state and local public health systems in the US. Along with the CDC and several key associations such as the National Association of County and City Health Officials (NACCHO) and the American Public Health Association (APHA), the PHPPO created the National Public Health Performance Standards Program. Improving quality is the overriding emphasis within the Standards Program; it is meant to stimulate a deliberate focus on improving the capacity of public health systems to provide the essential services of public health. (4)

Recently the partnership released separate sets of performance standards for local public health governance, for local jurisdictions and for state level programs. The standards are based on the core public health functions of Assessment, Policy Development and Assurance, as well as the nationally recognized ten essential services related to each of these core functions. These instruments use a self-assessment form of evaluation in which the entity evaluates itself against standards that describe an aspect of optimum performance on an indicator. Measures and sub-measures in the form of questions guide the self-evaluator through the set of standards and indicators. The result is then ranked on a percentile basis.

These standards and measures are a mixture of the accreditation model and the quality award model described above, although the self-assessment aspect represents a significant variation

from these models. The performance measurement approaches described above do not generally use a self-assessment type of evaluation. The Council on Accreditation does have an explicit step of self-assessment and system improvement prior to the accreditation survey. Most organizations preparing for JCAHO or NCQA surveys also perform a "mock" assessment as a part of their preparation activities. The actual review, however, is performed by outside surveyors.

Application to the Standards for Public Health in Washington State

Public health managers and staff are very familiar with program audits and more traditional types of quality assurance. Program audits continue to be a valuable method for evaluating individual program compliance with contract and licensure requirements. However, the Standards were adopted in this context—"It is expected that some standards will be beyond reach for some time to come. Yet, even these unmet standards will provide an important guidepost for our future and a way to measure progress as we work toward meeting them".

The Baseline Evaluation

To evaluate the performance of Washington's entire public health system, both state level and local levels, a systems evaluation approach was selected. The Standards Committee contracted with external reviewers to conduct an accreditation type of evaluation, rather than relying on a self-assessment model. The Standards Committee and the leadership of the Department of Health (DOH) and the Washington State Association of Local Public Health Officials (WSALPHO), through the reviewer selection process, specified which parts of the system they wanted to have evaluated. This translated into a baseline evaluation of 38 state-level programs located in five divisions and all (34) of the local health jurisdictions (LHJs) in the state.

The site reviewers used the Standards to conduct the baseline evaluation of the selected parts of the statewide system (this is the "organization" being reviewed). The selected DOH programs and the LHJs could not choose which standards and measures to be evaluated against. For the LHJs, each measure was considered applicable. For DOH programs, applicability of each measure to each program was established in advance of the site visits. The baseline evaluation included a self-assessment step in which each site completed a self-assessment tool regarding each applicable measure. Each site was asked to prepare for an on-site visit by organizing the documentation supporting the self-assessment on each measure. The site reviewer then evaluated the documentation and scored each measure.

Improvement or PDCA Cycle

Washington's public health performance standards and measures reflect an improvement cycle, as discussed above. An excellent example is the set of measures for communicable disease reporting and investigation. Written protocols are required for receiving and managing the communicable disease reports (the *plan* step). Several measures describe the requirements for communicating with providers and with law enforcement as well as training of local public health staff (the *do* step). Then a tracking system with at least annual evaluation of key indicators is required, as well as a debriefing process for major outbreaks (the *check* step). Finally, the implications for investigations, intervention, or educational efforts are measured (the *act* step). The improvement cycle is evident in many of the topics that are measured in Washington's standards for public health.

Scope of Review

Washington's performance standards also contain the three types of measures described earlier as "SAMPLE", "ALL", and "ONCE".

For SAMPLE review measures, only some of the DOH programs are evaluated against any given measure. In preparing the self-assessment, each DOH program or LHJ identified the program materials that would best demonstrate a measure. In future cycles, additional programmatic materials may be requested. It has been generally agreed that no organization in the system can demonstrate applicable measures in all areas of their work—this is another one of the ways in which these are stretch standards.

An example of an ALL measure is the measure requiring that all DOH staff and that all key LHJ staff be trained in emergency response plans. None of the programs or LHJs being reviewed can be excluded from being evaluated for this measure.

An example of the ONCE type of measure is the access measure that requires a single list of critical health services for the entire public health system. The reviewers need only to see this list once to evaluate performance for the entire organization. Individual programs within DOH do not need to demonstrate performance against this part of the measure once DOH overall has demonstrated it.

Partnership Measures

In the DOH, some of the performance measures were identified as partnership measures. When a specific DOH program could not fully meet the established measure without the direct contribution of several other programs it was called a partnership measure. In this case, the program identified which portion of the measure it contributed and provided the documentation of performance for that portion of the measure. A measure was not considered to be a partnership measure simply because the program could not demonstrate full performance of the measure. Some examples of partnership designation included: multiple programs contributed to a single product; components of the measure clearly required different pieces from different programs; or, there was a reference to a single or standard process or protocol. In the future, these DOH "partnership" measures will be the basis for "ONCE" measures, where the materials need to be presented once in the organization, not prepared, viewed and scored multiple times in multiple programs.

Program Capacity and System Performance

Program capacity and system performance are concepts used to assist in further understanding of the Washington State measurement system. Program capacity is used to describe the intended work of a specific program. This work may be subject to audit or program evaluation review, providing important information about the specific capacity (and performance) of that program.

System performance is used to describe the ability of the overall system to achieve specific measures or results. Actions taken by the system, if applied consistently, will improve the capacity (and performance) of each program within the system. For example:

The WIC program has staff, funding, contractual relationships and work processes to deliver services to a targeted number of specifically eligible clients. The services are clearly articulated, reflecting best practice knowledge, in order to assure standardized high quality services. This is the *program capacity.*

A specific measure—*Gaps in access to critical health services are identified using periodic survey data and other assessment information*—measures the system's performance using a sample of programs. This sampling process provides an overview of current *system performance* as well as program-specific exemplary practices. Subsequent adoption of an exemplary practice across all programs will improve each program's capacity (for example, WIC) to identify gaps in access, and should also result in integration of all access gap information into a system-wide picture. This is *system performance.*

Washington State's Use of the Baseline Evaluation

Like other organizations, Washington State's public health system will utilize the results of the baseline evaluation in several ways. The findings will be reported to each of the sites that are evaluated, accompanied by an aggregate report for all LHJs, the DOH, and the overall system. Management teams at all of these sites and levels of the public health system can and should use their specific reports to select the vital few areas for initiating local or system-wide quality improvement efforts.

The aggregate report will include qualitative information gathered in closing interviews at each site to describe the supports and resources needed to fully meet the measures. These support and resource needs will be reported for both the local and state levels. Under the auspices of the Public Health Improvement Plan, there are significant activities that will facilitate improving the performance and the documentation of work across the public health system:

- *Exemplary practices*: Exemplary practices will be collected from sites and collated into an online toolkit with hot links to each of the documents. DOH programs and local jurisdictions will be able to use this electronic compendium of exemplary practices to efficiently and effectively address gaps in documentation or performance.
- *Model policies and procedures*: The statewide nursing directors group is sponsoring an effort to build model policies and procedures from the exemplary practices.
- *Statewide initiatives*: Bioterrorism planning offers an opportunity to improve some areas of LHJ work. Other statewide projects such as The Health of Washington (a web-based report) or LHJ software design and installation also serve improvement of practice and documentation. Based on the recommendations in the system-wide report, the PHIP process may adopt additional statewide initiatives related to the measures.

(1) Lichiello, Patricia; Turning Point Guidebook for Performance Measurement, Turning Point National Program Office, December 1999.
(2) Ibid
(3) Ibid
(4) Halverson, Paul K.; *Performance Measurement and Performance Standards: Old Wine in New Bottles*, Journal of Public Health management and Practice, vol.6, No.5, September 2000

XII. Attachment E: Consulting Team

Barbara Mauer, MSW CMC

Ms. Mauer specializes in consulting with public and private sector healthcare and human service organizations. She has successfully led strategic planning, quality improvement, and complex project management engagements and has been a leader in the use of measurement as an integral part of planning for and managing health and human services. Prior to establishing a consulting practice, she held senior management positions within a large staff model HMO and a large county human services department. Ms. Mauer is the co-author, with Margot Kravette, of The Primary Care Performance Management System: A Team Approach to Winning in the New Healthcare Market, published by Manisses.

Marlene Mason, BSN, MBA

Ms. Mason is a versatile healthcare management consultant with extensive experience in the establishment and implementation of quality programs in health plans and integrated delivery systems. She also has expertise in assessment and compliance with quality standards such as the Baldrige Criteria, the National Committee for Quality Assurance (NCQA), and HCFA's QISMC standards. As an excellent communicator who quickly builds trust and instills a spirit of cooperation in achieving desired results, she has a proven track record in managing, consulting and facilitating the integration of management and decision making processes.

Bruce Brown, Ph.D.

Bruce Brown has over twenty-five years experience as a Research/Evaluation Methodologist, eight years experience as Program and Executive Director in the healthcare field, and eleven years experience as Assistant and Associate Professor of Sociology. His expertise includes research design, program evaluation, and statistical analysis. His research has been presented at numerous professional conferences and published in books and scientific journals.

Katherine G. Schomer, M.A.

Katherine Schomer has over eight years experience with project coordination, management, and market research. Ms. Schomer has extensive experience in developing and managing customer satisfaction surveys, research databases, and survey design, as well as utilizing skills such as market segmentation and structural equation models. Her broad base of experiences in industry analysis includes work in the fields of financial services, telecommunications, software/hardware, aerospace, healthcare, insurance and utilities.

XIII. Attachment F: Proposed Changes to Measures

PROPOSED MODIFICATIONS TO MEASURES

LOCAL HEALTH JURISDICTION VERSION

Understanding Health Issues: Standards for Public Health Assessment

ASSESSMENT Standard 1: Public health assessment skills and tools are in place in all public health jurisdictions and their level is continuously maintained and enhanced.

Number	Measure	Proposed Modifications to Measure
AS 1 1 AS L 1.2.1	Current information on health issues affecting the community is readily accessible, including standardized quantitative and qualitative data.	None
AS 1 2 AS L 1.4.2	There is a written procedure describing how and where to obtain technical assistance on assessment issues.	None
AS 1 3 AS L 1.5.3	Goals and objectives are established for assessment activities as a part of LHJ planning, and staff or outside assistance is identified to perform the work.	None
AS 1 4 AS L 1.6.4	Information on health issues affecting the community is updated regularly and includes information on communicable disease, environmental health and data about health status. Data being tracked have standard definitions, and standardized qualitative or quantitative measures are used. Computer hardware and software is available to support word processing, spreadsheets, with basic analysis capabilities, databases and Internet access.	None
AS 1 5 AS L 1.7.5	Staff who perform assessment activities have documented training and experience in epidemiology, research, and data analysis. Attendance at training and peer exchange opportunities to expand available assessment expertise is documented.	None

ASSESSMENT Standard 2: Information about environmental threats and community health status is collected, analyzed and disseminated at intervals appropriate for the community.

Number	Measure	Proposed Modifications to Measure
AS 2 1 AS L 2.2.1	Assessment data is provided to community groups and representatives of the broader community for review and identification of emerging issues that may require investigation.	None
AS 2 2 AS L 2.3.2	The Board of Health receives information on local health indicators at least annually.	Reword: The BOH receives a report annually on a core set of indicators that includes information on communicable disease, environmental health and data about health status. (clarification)
AS 2 3 AS L 2.4.3	Assessment procedures describe how population level investigations are carried out for documented or emerging health issues and problems.	Reword: There is a planned, systematic process that describes how documented or emerging health issues are identified, assessment data gathered and analyzed, and conclusions drawn regarding actions required. (clarification)
AS 2 4 AS L 2.5.4	Assessment investigations of changing or emerging health issues are part of the LHJ's annual goals and objectives.	None
AS 2 5 AS L 2.6.5	A core set of health status indicators, which may include selected local indicators, is used as the basis for continuous monitoring of the health status of the community. A surveillance system using monitoring data is maintained to signal changes in priority health issues.	Reword: A core set of indicators that includes information on communicable disease, environmental health and data about health status is used as the basis for continuous monitoring of the health status of the community. This surveillance system tracks data from year to year to signal changes in priority health issues. (clarification)

ASSESSMENT Standard 3: Public health program results are evaluated to document effectiveness.

Number	Measure	Proposed Modifications to Measure
AS 3 1 AS L 3.3.1	The annual report to the BOH includes progress toward program goals.	Reword: There is annual reporting to the BOH regarding progress toward program goals via a single compiled report or a planned calendar of reports. (clarification)

AS 3 2 AS L 3.5.2	There is a written procedure for using appropriate data to evaluate program effectiveness. Programs, whether provided directly or contracted, have written goals, objectives, and performance measures, and are based on relevant research.	Reword: There is a planned, systematic process that describes how appropriate data is used to evaluate program effectiveness. Programs, whether provided directly or contracted, have written goals, objectives, and performance measures, and are based on relevant research. (clarification)
AS 3 3 AS L 3.5.3	Program performance measures are monitored, the data is analyzed, and regular reports document the progress towards goals.	None
AS 3 4 AS L 3.7.4	LHJ program staff have training in methods to evaluate performance against goals and assess program effectiveness.	None
AS 3 5 AS L 3.8.5	Changes in activities that are based on analysis of key indicator data or performance measurement data are summarized as a part of quality improvement activities.	Reword: There is documentation that programs analyze and use performance monitoring data to change and improve program offerings. (clarification)

ASSESSMENT Standard 4: Health policy decisions are guided by health assessment information, with involvement of representative community members.

Number	Measure	Proposed Modifications to Measure
AS 4 1 AS L 4.2.1	There is documentation of community involvement in the process of reviewing data and recommending action such as further investigation, new program effort or policy direction.	None
AS 4 2 AS L 4.3.2	The annual report to the BOH summarizes assessment data, including environmental health, and the recommended actions for health policy decisions as evidenced through program, budget, and grant applications.	Reword: Health policy decisions, as evidenced through program, budget, and grant applications, are based upon the core set of indicators data and related recommendations for action that has been reported to the BOH. (clarification)
AS 4 3 AS L 4.4.3	There is a written protocol for developing recommendations for action using health assessment information to guide health policy decisions.	Reword: There is a planned systematic process that describes how health assessment data is used to guide health policy decisions. (clarification)
AS 4 4 AS L 4.5.4	Key indicator data and related recommendations are used in evaluating goals and objectives.	None

ASSESSMENT Standard 5: Health data is handled so that confidentiality is protected and health information systems are secure.

Number	Measure	Proposed Modifications to Measure
AS 5 1 AS L 5.2.1	Community members and stakeholders that receive data have demonstrated agreement to comply with confidentiality policies and practices, as appropriate.	None
AS 5 2 AS L 5.4.2	There are written policies regarding confidentiality. Written policies, including data sharing agreements, govern the use, sharing and transfer of data within the LHJ and with partner agencies. Written protocols are followed for assuring protection of data (passwords, firewalls, backup systems) and data systems.	This may be part of administrative standards in the future.
AS 5 3 AS L 5.4.3	All program data are submitted to local, state, regional and federal agencies in a confidential and secure manner.	This may be part of administrative standards in the future.
AS 5 4 AS L 5.7.4	Employees are trained regarding confidentiality, including those who handle patient information and clinical records, as well as those handling data.	None
AS 5 5 AS L 5.7.5	All employees and BOH members, as appropriate, have signed confidentiality agreements.	None

Protecting People from Disease: Standards for Communicable Disease and Other Health Risks

COMMUNICABLE DISEASE Standard 1: A surveillance and reporting system is maintained to identify emerging health threats.

Number	Measure	Proposed Modifications to Measure
CD 1 1 CD L 1.1.1	Information is provided on how to contact the LHJ to report a public health concern 24 hours per day. Law enforcement has current local and state 24-hour emergency contact lists.	Reword: Information is provided to the public on how to contact the LHJ to report a public health concern 24 hours per day. Law enforcement has current local and state 24-hour emergency contact lists. (consistency with EH 2.1.1)
CD 1 2 CD L 1.2.2	Health care providers and laboratories know which diseases require reporting, have timeframes, and have 24-hour local contact information. There is a process for identifying new providers in the community and engaging them in the reporting process.	None

CD 1 3 CD L 1.3.3	The local BOH receives an annual report, one element of which summarizes communicable disease surveillance activity.	Reword: Reports to the BOH include an annual report of communicable disease surveillance activity and related data from the core set of indicators. (clarification)
CD 1 4 CD L 1.4.4	Written protocols are maintained for receiving and managing information on notifiable conditions. The protocols include role-specific steps to take when receiving information as well as guidance on providing information to the public.	None
CD 1 5 CD L 1.5.5	Communicable disease key indicators and implications for investigation, intervention or education efforts are evaluated annually.	Reword: The core set of indicators relating to communicable disease are analyzed annually, and implications for changes in investigation, intervention or education efforts are identified. (clarification)
CD 1 6 CD L 1.6.6	A communicable disease tracking system is used which documents the initial report, investigation, findings and subsequent reporting to state and federal agencies.	None
CD 1 7 CD L 1.7.7	Staff members receive training on communicable disease reporting, as evidenced by local protocols.	Reword: Staff members receive training on reporting of communicable disease, as evidenced by training documentation. (clarification)

COMMUNICABLE DISEASE Standard 2: Response plans delineate roles and responsibilities in the event of communicable disease outbreaks and other health risks that threaten the health of people.

Number	Measure	Proposed Modifications to Measure
CD 2 1 CD L 2.1.1	Phone numbers for weekday and after-hours emergency contacts are available to DOH and appropriate local agencies, such as schools and public safety.	Reword: Phone numbers for weekday and after-hours emergency contacts are available to DOH and appropriate local agencies, such as schools and hospitals. (eliminate duplication of law enforcement reference with CD 1.1.1)
CD 2 2 CD L 2.2.2	A primary contact person or designated phone line for the LHJ is clearly identified in communications to health providers and appropriate public safety officials for reporting purposes.	None
CD 2 3	Written policies or procedures delineate specific roles and	None

CD L 2.4.3	responsibilities within agency divisions for local response and case investigations of disease outbreaks and other health risks.	

COMMUNICABLE DISEASE Standard 3: Communicable disease investigation and control procedures are in place and actions documented.

Number	Measure	Proposed Modifications to Measure
CD 3 1 CD L 3.2.1	Lists of private and public sources for referral to treatment are accessible to LHJ staff.	None
CD 3 2 CD L 3.2.2	Information is given to local providers through public health alerts and newsletters about managing reportable conditions.	None
CD 3 3 CD L 3.4.3	Communicable disease protocols require that investigation begin within 1 working day, unless a disease-specific protocol defines an alternate time frame. Disease-specific protocols identify information about the disease, case investigation steps, reporting requirements, contact and clinical management (including referral to care), use of emergency biologics, and the process for exercising legal authority for disease control (including non-voluntary isolation). Documentation demonstrates staff member actions are in compliance with protocols and state statutes.	Reword: Disease-specific protocols identify information about the disease, case investigation steps (including timeframes for initiating the investigation), reporting requirements, contact and clinical management (including referral to care), use of emergency biologics, and the process for exercising legal authority for disease control (including non-voluntary isolation). Documentation demonstrates staff member actions are in compliance with protocols and state statutes. (reorder to focus on the protocols)
CD 3 4 CD L 3.5.4	An annual evaluation of a sample of communicable disease investigations is done to monitor timeliness and compliance with disease-specific protocols.	Reword: An annual self-audit of a sample of communicable disease investigations is done to monitor timeliness and compliance with disease-specific protocols. (clarification)
CD 3 5 CD L 3.6.5	LHJs identify key performance measures for communicable disease investigation and enforcement actions.	None
CD 3 6 CD L 3.7.6	Staff members conducting disease investigations have appropriate skills and training as evidenced in job descriptions and resumes.	None

COMMUNICABLE DISEASE Standard 4: Urgent public health messages are communicated quickly and clearly and actions are documented.

Number	Measure	Proposed Modifications to Measure
CD 4 1 CD L 4.1.1	Information is provided through public health alerts to key stakeholders and press releases to the media.	None
CD 4 2 CD L 4.2.2	A current contact list of media and providers is maintained and updated at least annually. This list is in the communicable disease manual and at other appropriate departmental locations.	None
CD 4 3 CD L 4.4.3	Roles are identified for working with the news media. Policies identify the timeframes for communication and the expectations of all staff regarding information sharing and response to questions, as well as the steps for creating and distributing clear and accurate public health alerts and media releases.	None
CD 4 4 CD L 4.7.4	Staff who have lead roles in communicating urgent messages have been trained in risk communications.	Reword: All staff that have lead roles in communicating urgent messages have been trained in risk communications. (reduce duplication with EH 2.7.5, clarify application across program areas)

COMMUNICABLE DISEASE Standard 5: Communicable disease and other health risk responses are routinely evaluated for opportunities for improving public health system response.

Number	Measure	Proposed Modifications to Measure
CD 5 1 CD L 5.2.1	An evaluation for each significant outbreak response documents what worked well and what process improvements are recommended for the future. Feedback is solicited from appropriate entities, such as hospitals and providers. Meetings are convened to assess how the outbreak was handled, identify issues and recommend changes in response procedures.	None
CD 5 2 CD L 5.3.2	Findings and policy recommendations for effective response efforts are included in reports to the BOH.	Reword: Recommendations based on the outbreak evaluation and recommendations for effective response efforts are reported to the BOH. (clarification)

CD 5 3 CD L 5.4.3	Local protocols are revised based on local review findings and model materials disseminated by DOH.	Reword: Local protocols are revised based on outbreak evaluation findings or model materials disseminated by DOH. (clarification)
CD 5 4 CD L 5.5.4	Issues identified in outbreak evaluations are addressed in future goals and objectives for communicable disease programs.	None
CD 5 5 CD L 5.7.5	Staff training in communicable disease and other health risk issues is documented.	None
CD 5 6 CD L 5.8.6	A debriefing process for review of response to public health threats or disease outbreaks is included in the quality improvement plan and includes consideration of surveillance, staff roles, investigation procedures, and communication.	Reword: There is documentation that the outbreak evaluation findings are utilized for process improvement, including consideration of the surveillance process, staff roles, investigation procedures and communication efforts. (clarification)

Assuring a Safe, Healthy Environment for People: Standards for Environmental Health

ENVIRONMENTAL HEALTH Standard 1: Environmental health education is a planned component of public health programs.

Number	Measure	Proposed Modifications to Measure
EH 1 1 EH L 1.1.1	Information is available about environmental health educational programs through brochures, flyers, newsletters, websites and other mechanisms.	None
EH 1 2 EH L 1.2.2	There are documented processes for involving community members and stakeholders in addressing environmental health issues including education and the provision of technical assistance.	None
EH 1 3 EH L 1.5.3	A plan for environmental health education exists and includes goals, objectives and learning outcomes.	None
EH 1 4 EH L 1.6.4	The environmental health education plan identifies performance measures for education programs. There is an evaluation process for health education offerings that is used to revise curricula.	None
EH 1 5	Staff members conducting environmental health education have appropriate skills and training.	Reword: Staff members conducting health education sessions and

EH L 1.7.5		courses regarding environmental health issues have appropriate health education skills and training. (clarification)

ENVIRONMENTAL HEALTH Standard 2: Services are available throughout the state to respond to environmental events or natural disasters that threaten the public's health.

Number	Measure	Proposed Modifications to Measure
EH 2 1 EH L 2.1.1	Information is provided to the public on how to report environmental health threats or public health emergencies, 24 hours a day; this includes a phone number.	Reword: Information is provided to the public on how to contact local jurisdictions to report environmental health threats or public health emergencies, 24 hours a day; this includes a phone number. (consistency with CD 1.1.1)
EH 2 2 EH L 2.2.2	Appropriate stakeholders are engaged in developing emergency response plans. Following an emergency response to an environmental health problem or natural disaster, stakeholders are convened to review how the situation was handled, and this debriefing is documented with a written summary of findings and recommendations.	None
EH 2 3 EH L 2.4.3	Procedures are in place to monitor access to services and to evaluate the effectiveness of emergency response plans. Findings and recommendations for emergency response policies are included in reports to the BOH.	Reword: Procedures are in place to monitor public access to needed health care during an emergency response. The debriefing evaluation includes review of how well the public was able to access services. The findings and recommendations from the debriefing evaluation are provided to the BOH. (clarification)
EH 2 4 EH L 2.5.4	There is a plan that describes LHJ internal roles and responsibilities for environmental events or natural disasters that threaten the health of the people. There is a clear link between this plan and other local emergency response plans.	None
EH 2 5 EH L 2.7.5	Key staff members are trained in risk communication and use of the LHJ emergency response plan.	Reword: All staff members are trained in the LHJ emergency response plan and their internal roles as described in the plan. (eliminate duplication with CD 4.7.4, refocus on emergency response training)

ENVIRONMENTAL HEALTH Standard 3: Both environmental health risks and environmental health illnesses are tracked, recorded and reported.

Number	Measure	Proposed Modifications to Measure
EH 3 1 EH L 3.2.1	Environmental health data is available for community groups and other local agencies to review.	None
EH 3 2 EH L 3.6.2	A surveillance system is in place to record and report key indicators for environmental health risks and related illnesses. Information is tracked and trended over time to monitor trends. A system is in place to assure that data is shared routinely to local, state and regional agencies.	None
EH 3 3 EH L 3.8.3	A quality improvement plan includes consideration of environmental health information and trends, findings from public input, evaluation of health education offerings, and information from compliance activity.	None

ENVIRONMENTAL HEALTH Standard 4: Compliance with public health regulations is sought through enforcement actions.

Number	Measure	Proposed Modifications to Measure
EH 4 1 EH L 4.1.1	Written policies, local ordinances, laws and administrative codes are accessible to the public.	None
EH 4 2 EH L 4.4.2	Compliance procedures are written for all areas of environmental health activity. The procedures specify the documentation requirements associated with enforcement action. Documentation demonstrates that environmental health work conforms with policies, local ordinances and state statutes.	None
EH 4 3 EH L 4.5.3	There is a documented process for periodic review of enforcement actions.	Reword: An annual self-audit of a sample of environmental health case files is done to monitor timeliness and compliance with enforcement procedures. (clarification)
EH 4 4 EH L 4.6.4	An environmental health tracking system enables documentation of the initial report, investigation, findings, enforcement, and subsequent reporting to other agencies as required.	None

EH 4 5 EH L 4.7.5	Environmental health staff members are trained on compliance procedures, as evidenced by training documentation.	None

Prevention is Best: Promoting Healthy Living: Standards for Prevention and Community Health Promotion

PREVENTION AND PROMOTION Standard 1: Policies are adopted that support prevention priorities and that reflect consideration of scientifically-based public health literature.

Number	Measure	Proposed Modifications to Measure
PP 1 1 PP L 1.2.1	Prevention and health promotion priorities are selected with involvement from the BOH, community groups and other organizations interested in the public's health.	Reword: Prevention and health promotion priorities are selected with involvement from community groups and other organizations interested in the public's health. (delete duplication of BOH mention in PP 1.3.2)
PP 1 2 PP L 1.3.2	Prevention and health promotion priorities are adopted by the BOH, based on assessment information, local issues, funding availability, program evaluation, and experience in service delivery, including information on best practices or scientific findings.	None
PP 1 3 PP L 1.5.3	Prevention and health promotion priorities are reflected in the goals, objectives and performance measures of the LHJ's annual plan. Data from program evaluation and key indicators is used to develop strategies.	None

PREVENTION AND PROMOTION Standard 2: Active involvement of community members is sought in addressing prevention priorities.

Number	Measure	Proposed Modifications to Measure
PP 2 1 PP L 2.2.1	The LHJ provides leadership in involving community members in considering assessment information to set prevention priorities.	Reword: The LHJ provides leadership in involving community members and includes a broad range of community partners in considering assessment information to set prevention priorities. (eliminate duplication of PP 2.2.2)
PP 2 2	A broad range of community partners takes part in planning and implementing prevention and health	Delete (eliminate duplication)

PP L 2.2.2	promotion efforts to address selected priorities for prevention and health promotion.	
PP 2 3 PP L 2.7.3	Staff members have training in community mobilization methods as evidenced by training documentation.	None

PREVENTION AND PROMOTION Standard 3: Access to high quality prevention services for individuals, families, and communities is encouraged and enhanced by disseminating information about available services and by engaging in and supporting collaborative partnerships.

Number	Measure	Proposed Modifications to Measure
PP 3 1 PP L 3.1.1	Summary information is available to the public describing preventive services available in the community. This may be produced by a partner organization or the LHJ, and it may be produced in a paper or web-based format.	None
PP 3 2 PP L 3.6.2	Local prevention services are evaluated and a gap analysis that compares existing community prevention services to projected need for services is performed periodically and integrated into the priority setting process.	None
PP 3 3 PP L 3.5.3	Results of prevention program evaluation and analysis of service gaps are reported to local stakeholders and to peers in other communities.	None
PP 3 4 PP L 3.7.4	Staff have training in program evaluation methods as evidenced by training documentation.	Delete (eliminate duplication of AS 3.7.4)
PP 3 5 PP L 3.8.5	A quality improvement plan incorporates program evaluation findings, evaluation of community mobilization efforts, use of emerging literature and best practices and delivery of prevention and health promotion services.	None

PREVENTION AND PROMOTION Standard 4: Prevention, early intervention and outreach services are provided directly or through contracts.

Number	Measure	Proposed Modifications to Measure
PP 4 1 PP L 4.3.1	Prevention priorities adopted by the BOH are the basis for establishing and delivering prevention, early intervention and outreach services.	None
PP 4 2	Early intervention, outreach and health education materials address the diverse local population and	None

PP L 4.4.2	languages of the intended audience. Information about how to select appropriate materials is available to and used by staff.	
PP 4 3 PP L 4.5.3	Prevention programs collect and use information from outreach, screening, referrals, case management and follow-up for program improvement. Prevention programs, provided directly or by contract, are evaluated against performance measures and incorporate assessment information. The type and number of prevention services are included in program performance measures.	None
PP 4 4 PP L 4.7.4	Staff providing prevention, early intervention or outreach services have appropriate skills and training as evidenced by job descriptions, resumes or training documentation.	None

PREVENTION AND PROMOTION Standard 5: Health promotion activities are provided directly or through contracts.

Number	Measure	Proposed Modifications to Measure
PP 5 1 PP L 5.1.1	Health promotion activities are provided directly by LHJs or by contractors and are intended to reach the entire population or at-risk populations in the community.	Reword: Health promotion activities intended to reach the entire population or at-risk populations in the community are provided directly by LHJs or by contractors. (clarification)
PP 5 2 PP L 5.4.2	Procedures describe an overall system to organize, develop, distribute, evaluate, and update health promotion materials. Technical assistance is provided to community organizations, including "train the trainer" methods.	None
PP 5 3 PP L 5.5.3	Health promotion efforts have goals, objectives and performance measures. The number and type of health promotion activities are tracked and reported, including information on content, target audience, number of attendees. There is an evaluation process for health promotion efforts that is used to improve programs or revise curricula.	None
PP 5 4 PP L 5.7.4	Staff members have training in health promotion methods as evidenced by training documentation.	None

Helping People Get the Services They Need: Standards for Access to Critical Health Services

ACCESS Standard 1: Information is collected and made available at both the state and local level to describe the local health system, including existing resources for public health protection, health care providers, facilities, and support services.

Number	Measure	Proposed Modifications to Measure
AC 1 1 AC L 1.1.1	Up-to-date information on local critical health services is available for use in building partnerships with community groups and stakeholders.	Reword: Up-to-date analysis of local critical health services is available for use in building partnerships with community groups and stakeholders. (clarification)
AC 1 2 AC L 1.4.2	LHJ staff and contractors have a resource list of local providers of critical health services for use in making client referrals.	None
AC 1 3 AC L 1.5.3	The list of critical health services is used along with assessment information to determine where detailed documentation of local capacity is needed.	None

ACCESS Standard 2: Available information is used to analyze trends, which over time, affect access to critical health services.

Number	Measure	Proposed Modifications to Measure
AC 2 1 AC L 2.6.1	Data tracking and reporting systems include key measures of access. Periodic surveys are conducted regarding the availability of critical health services and barriers to access.	None
AC 2 2 AC L 2.5.2	Gaps in access to critical health services are identified using periodic survey data and other assessment information.	Reword: Gaps in access to critical health services are identified through analysis of the results of periodic surveys and other data tracking. (clarification)
AC 2 3 AC L 2.3.3	The BOH receives summary information regarding access to critical health services at least annually.	None

ACCESS Standard 3: Plans to reduce specific gaps in access to critical health services are developed and implemented through collaborative efforts.

Number	Measure	Proposed Modifications to Measure
AC 3 1	Community groups and stakeholders, including health care providers, are convened to address access to critical	None

AC L 3.2.1	health services, set goals and take action, based on information about local resources and trends. This process may be led by the LHJ or it may be part of a separate community process sponsored by multiple partners, including the LHJ.	
AC 3 2 AC L 3.2.2	Coordination of critical health service delivery among health providers is reflected in the local planning processes and in the implementation of access initiatives.	None
AC 3 3 AC L 3.5.3	Where specific initiatives are selected to improve access, there is analysis of local data and established goals, objectives, and performance measures.	None

ACCESS Standard 4: Quality measures that address the capacity, process for delivery and outcomes of critical health services are established, monitored and reported.

Number	Measure	Proposed Modifications to Measure
AC 4 1 AC L 4.8.1	Clinical services provided directly by the LHJ or by contract have a written quality improvement plan including specific quality-based performance or outcome measures. Performance measures are tracked and reported.	None
AC 4 2 AC L 4.7.2	Staff members are trained in quality improvement methods as evidenced by training documentation.	None

PROPOSED ALTERATIONS TO STANDARDS AND MEASURES

DEPARTMENT OF HEALTH PROGRAM VERSION

Understanding Health Issues: Standards for Public Health Assessment

ASSESSMENT Standard 1: Public health assessment skills and tools are in place in all public health jurisdictions and their level is continuously maintained and enhanced.

Number	Measure	Proposed Modified Language
AS 1 1 AS s 1.2.1	Consultation and technical assistance are provided to LHJs and state programs on health data collection and analysis, as documented by logs or reports. Coordination is provided in the development and use of data standards, including definitions and descriptions.	None
AS 1 2 AS s 1.4.2	Written procedures are maintained and disseminated for how to obtain consultation and technical assistance for LHJs or state programs regarding health data collection and analysis, and program evaluation.	None
AS 1 3 AS s 1.5.3	Goals and objectives are established for assessment activities as a part of DOH planning, and resources are identified to perform the work.	None
AS 1 4 AS s 1.6.4	Information on health issues affecting the state is updated regularly and includes information on communicable disease, environmental health and data about health status. Data being tracked have standard definitions, and standardized qualitative or quantitative measures are used. Computer hardware and software is available to support word processing, spreadsheets, complex analysis capabilities, databases and Internet access.	None
AS 1 5 AS s 1.7.5	Staff members who perform assessment activities have documented training and experience in epidemiology, research, and data analysis. Statewide training and peer exchange opportunities are coordinated and documented.	None

ASSESSMENT Standard 2: Information about environmental threats and community health status is collected, analyzed and disseminated at intervals appropriate for the community.

Number	Measure	Proposed Modified Language
AS 2 1 AS s 2.2.1	Reports are provided to LHJs and other groups. The reports provide health information analysis and include key health indicators tracked over time.	None
AS 2 2 AS s 2.6.2	A core set of health status indicators is used as the basis for continuous monitoring of the health status of the state, and results are published at scheduled intervals. A surveillance system using monitoring data is maintained to signal changes in priority health issues.	Reword: A core set of indicators that includes information on communicable disease, environmental health and data about health status is regularly published and used as the basis for continuous monitoring of the health status of the state. This surveillance system tracks data from year to year to signal changes in priority health issues. (clarification)
AS 2 3 AS s 2.4.3	Written procedures describe how population level investigations are carried out in cooperation with LHJs in response to known or emerging health issues. The procedures included expected time frames for response.	Reword: There is a planned, systematic process that describes how documented or emerging health issues are identified, assessment data gathered and analyzed, LHJs involved as appropriate, and conclusions drawn regarding actions required. (clarification)
AS 2 4 AS s 2.5.4	Investigations of changing or emerging health issues are part of the annual goals and objectives established by DOH.	None

ASSESSMENT Standard 3: Public health program results are evaluated to document effectiveness.

Number	Measure	Proposed Modified Language
AS 3 1 AS s 3.2.1	Consultation and technical assistance are provided to LHJs and state programs on program evaluation, as documented by case write-ups or logs.	None
AS 3 2 AS s 3.4.2	Programs administered by the DOH have written goals, objectives and performance measures, and are based on relevant research. There is a written protocol for using appropriate data to evaluate program effectiveness.	Reword: There is a planned, systematic process that describes how appropriate data is used to evaluate DOH program effectiveness. Programs, whether provided directly or contracted, have written goals, objectives, and performance measures, and are based on relevant research. (clarification)

AS 3 3 AS s 3.5.3	Program performance measures are monitored, the data is analyzed, and regular reports document the progress towards goals.	None
AS 3 4 AS s 3.7.4	State and LHJ staff members have been trained on program evaluation as evidenced by documentation of staff training.	None
AS 3 5 AS s 3.8.5	Changes in activities that are based on analysis of key indicator data or performance measurement data are summarized as a part of quality improvement activities.	Reword: There is documentation that programs analyze and use performance monitoring data to change and improve program offerings. (clarification)

ASSESSMENT Standard 4: Health Policy decisions are guided by health assessment information, with involvement of representative community members.

Number	Measure	Proposed Modified Language
AS 4 1 AS s 4.2.1	There is documentation of stakeholder involvement in DOH health assessment and policy development.	None
AS 4 2 AS s 4.4.2	There is a written protocol for using health assessment information to guide health policy decisions.	Reword: There is a planned systematic process that describes how health assessment data is used to guide health policy decisions. (clarification)
AS 4 3 AS s 4.4.3	State health assessment data is linked to health policy decisions, as evidenced through legislative requests, budget decisions, programs or grants.	None

ASSESSMENT Standard 5: Health data is handled so that confidentiality is protected and health information systems are secure.

Number	Measure	Proposed Modified Language
AS 5 1 AS s 5.2.1	Stakeholders that receive data have demonstrated agreement to comply with confidentiality policies and practices, as appropriate.	None
AS 5 2 AS s 5.4.2	There are written policies, including data sharing agreements, regarding confidentiality that govern the use, sharing and transfer of data within the DOH and among the DOH, LHJs and partner agencies. Written protocols are followed for assuring protection of data (passwords,	This may be part of administrative standards in the future.

	firewalls, backup systems) and data systems.	
AS 5 3 AS s 5.5.3	All program data are submitted to local, state, regional and federal agencies in a confidential and secure manner.	This may be part of administrative standards in the future.
AS 5 4 AS s 5.7.4	Employees are trained regarding confidentiality, including those who handle patient information and clinical records, as well as those handling data.	None
AS 5 5 AS s 5.7.5	All employees have signed confidentiality agreements.	None

Protecting People from Disease: Standards for Communicable Disease and Other Health Risks

COMMUNICABLE DISEASE Standard 1: A surveillance and reporting system is maintained to identify emerging health threats.

Number	Measure	Proposed Modified Language
CD 1 1 CD s 1.1.1	Information is provided to the public on how to contact the DOH to report a public health concern 24 hours per day. Law enforcement has current state 24-hour emergency contact lists.	None
CD 1 2 CD s 1.2.2	Consultation and technical assistance are provided to LHJs on surveillance and reporting, as documented by case summaries or reports. Laboratories and health care providers, including new licensees, are provided with information on disease reporting requirements, timeframes, and a 24-hour DOH point of contact.	None
CD 1 3 CD s 1.4.3	Written procedures are maintained and disseminated for how to obtain state or federal consultation and technical assistance for LHJs. Assistance includes surveillance, reporting, disease intervention management during outbreaks or public health emergencies, and accuracy and clarity of public health messages.	None
CD 1 4 CD s 1.5.4	Annual goals and objectives for communicable disease are a part of the DOH planning process. Key indicators and implications for investigation, intervention or education efforts are documented.	None

CD 1 5 CD s 1.6.5	A statewide database for reportable conditions is maintained, surveillance data are summarized and disseminated to LHJs at least annually. Uniform data standards and case definitions are updated and published at least annually.	None
CD 1 6 CD s 1.7.6	Staff members receive training on communicable disease reporting, as evidenced by protocols.	Reword: Staff members receive training on reporting of communicable disease, as evidenced by training documentation. (clarification)

COMMUNICABLE DISEASE Standard 2: Response plans delineate roles and responsibilities in the event of communicable disease outbreaks and other health risks that threaten the health of people.

Number	Measure	Proposed Modified Language
CD 2 1 CD s 2.1.1	Phone numbers for after-hours contacts for all local and state public health jurisdictions are updated and disseminated statewide at least annually.	None
CD 2 2 CD s 2.4.2	Written policies or procedures delineate specific roles and responsibilities for state response to disease outbreaks or public health emergencies. There is a formal description of the roles and relationship between communicable disease, environmental health and program administration. Variations from overall process are identified in disease-specific protocols.	None
CD 2 3 CD s 2.4.3	Written procedures describe how expanded lab capacity is made readily available when needed for outbreak response, and there is a current list of labs having the capacity to analyze specimens.	None
CD 2 4 CD s 2.7.4	DOH staff members receive training on the policies and procedures regarding roles and responsibilities for response to public health threats, as evidenced by protocols.	None

COMMUNICABLE DISEASE Standard 3: Communicable disease investigation and control procedures are in place and actions documented.

Number	Measure	Proposed Modified Language
CD 3 1 CD s 3.2.1	Consultation and staff time are provided to LHJs for local support of disease intervention management during outbreaks or public health emergencies, as documented by case write-ups. Recent research findings relating to the most effective population-based methods of disease prevention and control are provided to LHJs. Labs are provided written protocols for the handling, storage and transportation of specimens.	None
CD 3 2 CD s 3.4.2	DOH leads statewide development and use of a standardized set of written protocols for communicable disease investigation and control, including templates for documentation. Disease-specific protocols identify information about the disease, case investigation steps, reporting requirements, contact and clinical management (including referral to care), use of emergency biologics, and the process for exercising legal authority for disease control (including non-voluntary isolation). Documentation demonstrates staff member actions are in compliance with protocols and state statutes.	Reword: DOH leads statewide development and use of a standardized set of written protocols for communicable disease investigation and control, including templates for documentation. Disease-specific protocols identify information about the disease, case investigation steps (including timeframes for initiating investigations), reporting requirements, contact and clinical management (including referral to care), use of emergency biologics, and the process for exercising legal authority for disease control (including non-voluntary isolation). Documentation demonstrates staff member actions are in compliance with protocols and state statutes.
CD 3 3 CD s 3.5.3	An annual evaluation of a sample of state communicable disease investigation and consultations is done to monitor timeliness and compliance with disease-specific protocols.	Reword: An annual self-audit of a sample of DOH communicable disease investigations is done to monitor timeliness and compliance with disease-specific protocols. (clarification)
CD 3 4 CD s 3.6.4	DOH identifies key performance measures for communicable disease investigations and consultation.	None
CD 3 5 CD s 3.7.5	Staff members conducting disease investigations have appropriate skills and training as evidenced in job descriptions and resumes.	None

COMMUNICABLE DISEASE Standard 4: Urgent public health messages are communicated quickly and clearly and actions documented.

Number	Measure	Proposed Modified Language
CD 4 1 CD s 4.1.1	A communication system is maintained for rapid dissemination of urgent public health messages to the media and other state and national contacts.	None
CD 4 2 CD s 4.2.2	A communication system is maintained for rapid dissemination of urgent public health messages to LHJs, other agencies and health providers. Consultation is provided to LHJs to assure the accuracy and clarity of public health information associated with an outbreak or public health emergency, as documented by case write-up. State-issued announcements are shared with LHJs in a timely manner.	None
CD 4 3 CD s 4.4.3	Roles are identified for working with the news media. Written policies identify the timeframes for communication and the expectations of all staff regarding information sharing and response to questions, as well as the steps for creating and distributing clear and accurate public health alerts and media releases.	None
CD 4 4 CD s 4.5.4	Communication issues identified in outbreak response evaluations are addressed in writing with future goals and objectives in the communicable disease quality improvement plan.	None
CD 4 5 CD s 4.7.5	Staff members with lead roles in communicating urgent messages have been trained in risk communication.	Reword: All staff that have lead roles in communicating urgent messages have been trained in risk communications. (reduce duplication with EH 2.7.5, clarify application across program areas)

COMMUNICABLE DISEASE Standard 5: Communicable disease and other health risk responses are routinely evaluated for opportunities for improving public health system response.

Number	Measure	Proposed Modified Language
CD 5 1	Timely information about best practices in disease control is gathered and disseminated. Coordination is provided	None

CD s 5.2.1	for a state and local debriefing to evaluate extraordinary disease events that required a multi-agency response; a written summary of evaluation findings and recommendations is disseminated statewide.	
CD 5 2 CD s 5.4.2	Model plans, protocols and evaluation templates for response to disease outbreaks or public health emergencies are developed and disseminated to LHJs.	None
CD 5 3 CD s 5.5.3	Model materials are revised based on evaluation findings, including review of outbreaks.	None
CD 5 4 CD s 5.5.4	Response issues identified in outbreak evaluations are addressed in future goals and objectives for communicable disease programs.	None
CD 5 5 CD s 5.7.5	Staff members are trained in surveillance, outbreak response and communicable disease control, and are provided with standardized tools.	None
CD 5 6 CD s 5.8.6	A debriefing process for review of response to public health threats or disease outbreaks is included in the quality improvement plan and includes consideration of surveillance, staff roles, investigation procedures, and communication.	Reword: There is documentation that the outbreak evaluation findings are utilized for process improvement, including consideration of the surveillance process, staff roles, investigation procedures and communication efforts. (clarification)

Assuring a Safe, Healthy Environment for People: Standards for Environmental Health

ENVIRONMENTAL HEALTH Standard 1: Environmental health education is a planned component of public health programs.

Number	Measure	Proposed Modified Language
EH 1 1 EH s 1.1.1	Information is provided to the public about the availability of state level environmental health educational programs through contact information on brochures, flyers, newsletters, websites and other mechanisms.	None
EH 1 2 EH s 1.2.2	There are documented processes for involving stakeholders in addressing environmental health issues including education and the provision of technical assistance.	None
EH 1 3	A plan for environmental health education exists, with	None

EH s 1.5.3	goals, objectives and learning outcomes. There is an evaluation process for health education offerings that is used to revise curricula.	
EH 1 4 EH s 1.4.4	Environmental health education services are provided in conformance with the statewide plan.	None
EH 1 5 EH s 1.6.5	The environmental health education plan identifies performance measures for education programs that are monitored and analyzed on a routine basis.	None
EH 1 6 EH s 1.7.6	Staff members conducting environmental health education have appropriate health education skills and training as evidenced by job descriptions, resumes or training documentation.	Reword: Staff members conducting environmental education sessions and courses have appropriate health education skills and training as evidenced by job descriptions, resumes or training documentation. (clarification)

ENVIRONMENTAL HEALTH Standard 2: Services are available throughout the state to respond to environmental events or natural disasters that threaten the public's health.

Number	Measure	Proposed Modified Language
EH 2 1 EH s 2.1.1	Information is provided to the public on how to report environmental heath threats or public health emergencies, 24 hours a day; this includes a phone number.	None
EH 2 2 EH s 2.2.2	Consultation and technical assistance are provided to LHJs and other agencies on emergency preparedness, as documented by case write-ups or logs. Following an emergency response to an environmental health problem or natural disaster, LHJs and other agencies are convened to review how the situation was handled. This debriefing is documented with a written summary of findings and recommendations.	None
EH 2 3 EH s 2.4.3	Written procedures are maintained and disseminated for how to obtain consultation and technical assistance regarding emergency preparedness. Procedures are in place to monitor access to services and to evaluate the effectiveness of emergency response plans. Policies are revised based on event debriefing findings and recommendations.	Reword: Written procedures are maintained and disseminated for how to obtain consultation and technical assistance regarding emergency preparedness. Procedures are in place to monitor the public's access to health care services during an emergency response. Policies are revised based on event debriefing findings and recommendations. (clarification)

EH 2 4 EH s 2.5.4	There is a plan that describes DOH internal roles and responsibilities for environmental events or natural disasters that threaten the health of the people. There is a clear link between this plan and other state and local emergency response plans.	None
EH 2 5 EH s 2.7.5	All DOH program staff are trained in risk communication and use of the DOH emergency response plan, as evidenced by training documentation.	Reword: All staff members are trained in the DOH emergency response plan and their internal roles as described in the plan. (eliminate duplication with CD 4.7.4, refocus on emergency response training)

ENVIRONMENTAL HEALTH Standard 3: Both environmental health risks and environmental health illnesses are tracked, recorded and reported.

Number	Measure	Proposed Modified Language
EH 3 1 EH s 3.2.1	Coordination is provided in development of data standards for environmental health indicators. Information based on the surveillance system is developed and provided to LHJs and other state stakeholders.	Reword: The development of data standards for environmental health indicators is coordinated with LHJs and other stakeholders. (recombines these two measures to focus on separate aspects and reduce duplication)
EH 3 2 EH s 3.6.2	A statewide surveillance system is in place to receive, record and report key indicators for environmental health risks and related illnesses. Results are tracked and trended over time and reported regularly. A system is in place to assure that data is transferred routinely to local, state and regional agencies.	Reword: The development of data standards for environmental health indicators is coordinated with LHJs and other stakeholders. (recombines these two measures to focus on separate aspects and reduce duplication)
EH 3 3 EH s 3.8.3	A quality improvement plan includes consideration of analysis of environmental health information and trends, findings from debriefings, evaluation of health education offerings, and information from compliance activity.	None

ENVIRONMENTAL HEALTH Standard 4: Compliance with public health regulations is sought through enforcement actions.

Number	Measure	Proposed Modified Language
EH 4 1 EH s 4.1.1	Written policies, local ordinances, laws and administrative codes are accessible to the public.	None

EH 4 2 EH s 4.2.2	Information about best practices in environmental health compliance activity is gathered and disseminated, including form templates, time frames, interagency coordination steps, hearing procedures, citation issuance, and documentation requirements.	None
EH 4 3 EH s 4.4.3	Compliance procedures are written for all areas of environmental health activity carried out by DOH. Documentation demonstrates that environmental health work conforms with policies, local ordinances and state statutes.	None
EH 4 4 EH s 4.4.4	There is a documented process for periodic review of enforcement action.	Reword: An annual self-audit of a sample of environmental health case files is done to monitor timeliness and compliance with enforcement procedures. (clarification)
EH 4 5 EH s 4.6.5	An environmental health tracking system enables documentation of the initial report, investigation, findings, enforcement, and subsequent reporting to other agencies as required.	None
EH 4 6 EH s 4.7.6	Environmental health staff members are trained on compliance procedures, as evidenced by training documentation.	None

Prevention is Best: Promoting Healthy Living: Standards for Prevention and Community Health Promotion

PREVENTION AND PROMOTION Standard 1: Policies are adopted that support prevention priorities and that reflect consideration of scientifically-based public health literature.

Number	Measure	Proposed Modified Language
PP 1 1 PP s 1.1.1	Reports about new or emerging issues that contribute to health policy choices are routinely developed and disseminated. Reports include information about best practices in prevention and health promotion programs.	None
PP 1 2 PP s 1.2.2	Consultation and technical assistance is available to assist LHJs in proposing and developing prevention and health promotion policies and initiatives. Written procedures are maintained and shared, describing how to obtain	None

	consultation and assistance regarding development, delivery, or evaluation of prevention and health promotion initiatives.	
PP 1 3 PP s 1.5.3	Priorities are set for prevention and health promotion services, and a statewide implementation plan is developed with goals, objectives and performance measures.	None
PP 1 4 PP s 1.8.4	The statewide plan is evaluated and revised regularly, incorporating information from health assessment data and program evaluation.	None

PREVENTION AND PROMOTION Standard 2: Active involvement of community members is sought in addressing prevention priorities.

Number	Measure	Proposed Modified Language
PP 2 1 PP s 2.1.1	The DOH provides leadership in involving stakeholders in considering assessment information to set prevention and health promotion priorities.	Reword: The DOH provides leadership in involving community members and includes a broad range of community partners in considering assessment information to set prevention priorities. (eliminate duplication of PP 2.2.2)
PP 2 2 PP s 2.2.2	A broad range of partners takes part in planning and implementing prevention and health promotion efforts to address selected priorities for prevention and health promotion.	Delete (eliminate duplication)
PP 2 3 PP s 2.2.3	Information about community mobilization efforts for prevention priorities is collected and shared with LHJs and other stakeholders.	Reword: DOH collects information about successful community mobilization efforts led by DOH, LHJs or other stakeholders as a part of prevention programs. These examples are shared with other DOH programs, LHJs and stakeholders.
PP 2 4 PP s 2.5.4	The statewide plan for prevention and health promotion identifies efforts to link public and private partnerships into a network of prevention services.	None
PP 2 5 PP s 2.7.5	DOH staff members have training in community mobilization methods as evidenced by training documentation.	None

PREVENYTION AND PROMOTION Standard 3: Access to high quality prevention services for individuals, families, and communities is encouraged and enhanced by disseminating information about available services and by engaging in and supporting collaborative partnerships.

Number	Measure	Proposed Modified Language
PP 3 1 PP s 3.1.1	The DOH supports best use of available resources for prevention services through leadership, collaboration and communication with partners. Information about prevention and health promotion evaluation results is collected and shared statewide.	None
PP 3 2 PP s 3.5.2	Prevention programs, provided directly or by contract, are evaluated against performance measures and incorporate assessment information. In addition, a gap analysis that compares existing prevention services to projected need for services is performed periodically and integrated into the priority setting process.	None
PP 3 3 PP s 3.7.3	DOH staff members have training in program evaluation methods as evidenced by training documentation.	Delete (eliminate duplication of AS 3.7.4)
PP 3 4 PP s 3.8.4	A quality improvement plan incorporates program evaluation findings, evaluation of community mobilization efforts, use of emerging literature and best practices and delivery of prevention and health promotion services.	None

PREVENTION AND PROMOTION Standard 4: Prevention, early intervention and outreach services are provided directly or through contracts.

Number	Measure	Proposed Modified Language
PP 4 1 PP s 4.2.1	Consultation and technical assistance on program implementation and evaluation of prevention services is provided for LHJs. There is a system to inform LHJs and other stakeholders about prevention funding opportunities.	None
PP 4 2 PP s 4.4.2	Outreach and other prevention interventions are reviewed for compliance with science, professional standards, and state and federal requirements. Consideration of professional requirements and competencies for effective prevention staff is included.	None

PP 4 3 PP s 4.5.3	Prevention services have performance measures that are tracked and analyzed, and recommendations are made for program improvements.	None
PP 4 4 PP s 4.6.4	Statewide templates for documentation and data collection are provided for LHJs and other contractors to support performance measurement.	None
PP 4 5 PP s 4.7.5	DOH staff members have training in prevention, early intervention, or outreach services as evidenced by training documentation.	None

PREVENTION AND PROMOTION Standard 5: Health promotion activities are provided directly or through contracts.

Number	Measure	Proposed Modified Language
PP 5 1 PP s 5.1.1	Health promotion activities are provided directly by DOH or by contractors, and are intended to reach the entire population or at risk populations in the community.	Reword: Health promotion activities intended to reach the entire population or at-risk populations in the community are provided directly by DOH or by contractors. (clarification)
PP 5 2 PP s 5.2.2	Literature reviews of health promotion effectiveness are conducted and disseminated. Consultation and technical assistance on health promotion implementation and evaluation is provided for LHJs. There is a system to inform LHJs and other stakeholders about health promotion funding opportunities.	None
PP 5 3 PP s 5.4.3	Health promotion activities are reviewed for compliance with science, professional standards, and state and federal requirements. Health promotion materials that are appropriate for statewide use and for key cultural or linguistic groups are made available to LHJs and other stakeholders through a system that organizes, develops, distributes, evaluates and updates the materials.	None
PP 5 4 PP s 5.5.4	Health promotion activities have goals, objectives and performance measures that are tracked and analyzed, and recommendations are made for program improvements. The number and type of health promotion activities are tracked and reported, including information on content, target audience, number of attendees. There is an	None

	evaluation process for health promotion efforts that is used to improve programs or revise curricula.	
PP 5 5 PP s 5.7.5	DOH staff members have training in health promotion methods as evidenced by training documentation.	None

Helping People Get the Services They Need: Standards for Access to Critical Health Services

ACCESS Standard 1: Information is collected and made available at both the state and local level to describe the local health system, including existing resources for public health protection, health care providers, facilities, and support services.

Number	Measure	Proposed Modified Language
AC 1 1 AC s 1.6.1	A list of critical health services is established and a core set of statewide access measures established. Information is collected on the core set of access measures, analyzed and reported to the LHJs and other agencies.	None
AC 1 2 AC s 1.2.2	Information is provided to LHJs and other agencies about availability of licensed health care providers, facilities and support services.	None

ACCESS Standard 2: Available information is used to analyze trends, which over time, affect access to critical health services.

Number	Measure	Proposed Modified Language
AC 2 1 AC s 2.2.1	Consultation is provided to communities to help gather and analyze information about barriers to accessing critical health services.	None
AC 2 2 AC s 2.4.2	Written procedures are maintained and disseminated for how to obtain consultation and technical assistance for LHJs and other agencies in gathering and analyzing information regarding barriers to access.	None
AC 2 3 AC s 2.6.3	Gaps in access to critical health services are identified using periodic survey data and other assessment information.	Reword: Gaps in access to critical health services are identified through analysis of the results of periodic surveys and other data tracking. (clarification)
AC 2 4	Periodic studies regarding workforce needs and the effect	

AC s 2.7.4	on critical health services are conducted, incorporated into the gap analysis and disseminated to LHJs and other agencies.	

ACCESS Standard 3: Plans to reduce specific gaps in access to critical health services are developed and implemented through collaborative efforts.

Number	Measure	Proposed Modified Language
AC 3 1 AC s 3.2.1	Information about access barriers affecting groups within the state is shared with other state agencies that pay for or support critical health services.	None
AC 3 2 AC s 3.5.2	State-initiated contracts and program evaluations include performance measures that demonstrate coordination of critical health services delivery among health providers.	None
AC 3 3 AC s 3.4.3	Protocols are developed for implementation by state agencies, LHJs and other local providers to maximize enrollment and participation in available insurance coverage.	None
AC 3 4 AC s 3.8.4	Where specific initiatives are selected to improve access, there is analysis of local data and established goals, objectives, and performance measures.	None

ACCESS Standard 4: Quality measures that address the capacity, process for delivery and outcomes of critical health services are established, monitored and reported.

Number	Measure	Proposed Modified Language
AC 4 1 AC s 4.2.1	Information about best practices in delivery of critical health services is gathered and disseminated. Summary information regarding delivery system changes is provided to LHJs and other agencies.	None
AC 4 2 AC s 4.7.2	Training on quality improvement methods is available and is incorporated into grant and program requirements.	None
AC 4 3 AC s 4.8.3	Regulatory programs and clinical services administered by DOH have a written quality improvement plan including specific quality-based performance or outcome measures.	None

XIV. Attachment G: Proposed DOH Matrix for Future Review Cycles

XV. List of Charts and Tables

Chart 1	Understanding Health Issues: Demonstration Levels
Chart 2	Protecting People from Disease: Demonstration Levels
Chart 3	Assuring a Safe, Healthy Environment: Demonstration Levels
Chart 4	Prevention is Best: Promoting Healthy Living: Demonstration Levels
Chart 5	Helping People get the Services They Need: Demonstration Levels
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Chart 7	Overall LHJ Percent of Measures Demonstrated by Topic Area
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Chart 9	Protecting People from Disease: LHJ Percent Demonstrated
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