



2008 PUBLIC HEALTH IMPROVEMENT PLAN

Building Strength and Performance

PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND
HEALTHIER WASHINGTON

VISION STATEMENT ▶

Washington State's public health partners envision a public health system that promotes good health and provides improved protection from disease, injury, and hazards in the environment.

To help realize that goal, the public health system is committed to:

- ▶ Focusing our resources effectively, defining and monitoring outcomes for key public health issues and trends, and emphasizing evidence-based strategies;
- ▶ Maintaining a results-based accountability system, with meaningful performance measures and program evaluation;
- ▶ Using standardized technology across the public health system;
- ▶ Maintaining a workforce that is well-trained for current public health challenges and has access to continuous professional development;
- ▶ Facilitating discussions about health care access and delivery issues from the perspective of community systems, where the experiences of patients, providers, purchasers, and payers are important components;
- ▶ Applying communications strategies that are effective and foster greater public involvement in achieving public health goals; and
- ▶ Establishing new coalitions and alliances—among stakeholders, policy makers, and leaders—that support the mission of public health.

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LETTER FROM THE SECRETARY OF HEALTH ►



Dear Friends of Public Health,

I am pleased to share the *2008 Public Health Improvement Plan: Building Strength and Performance*.

The plan is an example of how the public health system works in Washington to improve the health of people and communities. This partnership includes local public health officials, state public health workers, the American Indian Health Commission, the state Board of Health, the University of Washington, the Washington Health Foundation, and the Washington State Public Health Association. I want to sincerely thank everyone who has had a hand in making this work.

We are in a time of economic challenge unlike any in recent times. With this challenge comes an opportunity to transform our public health system. This partnership is one of the most important ways we can build a strong and reliable public health system.

I am proud to be a part of Washington's public health community—innovative, passionate, and capable professionals—working together to address these challenging times.

Sincerely,

A handwritten signature in blue ink that reads "Mary C. Selecky". The signature is written in a cursive, flowing style.

Mary C. Selecky
Secretary of Health

PUBLIC HEALTH IMPROVEMENT PARTNERSHIP ▶

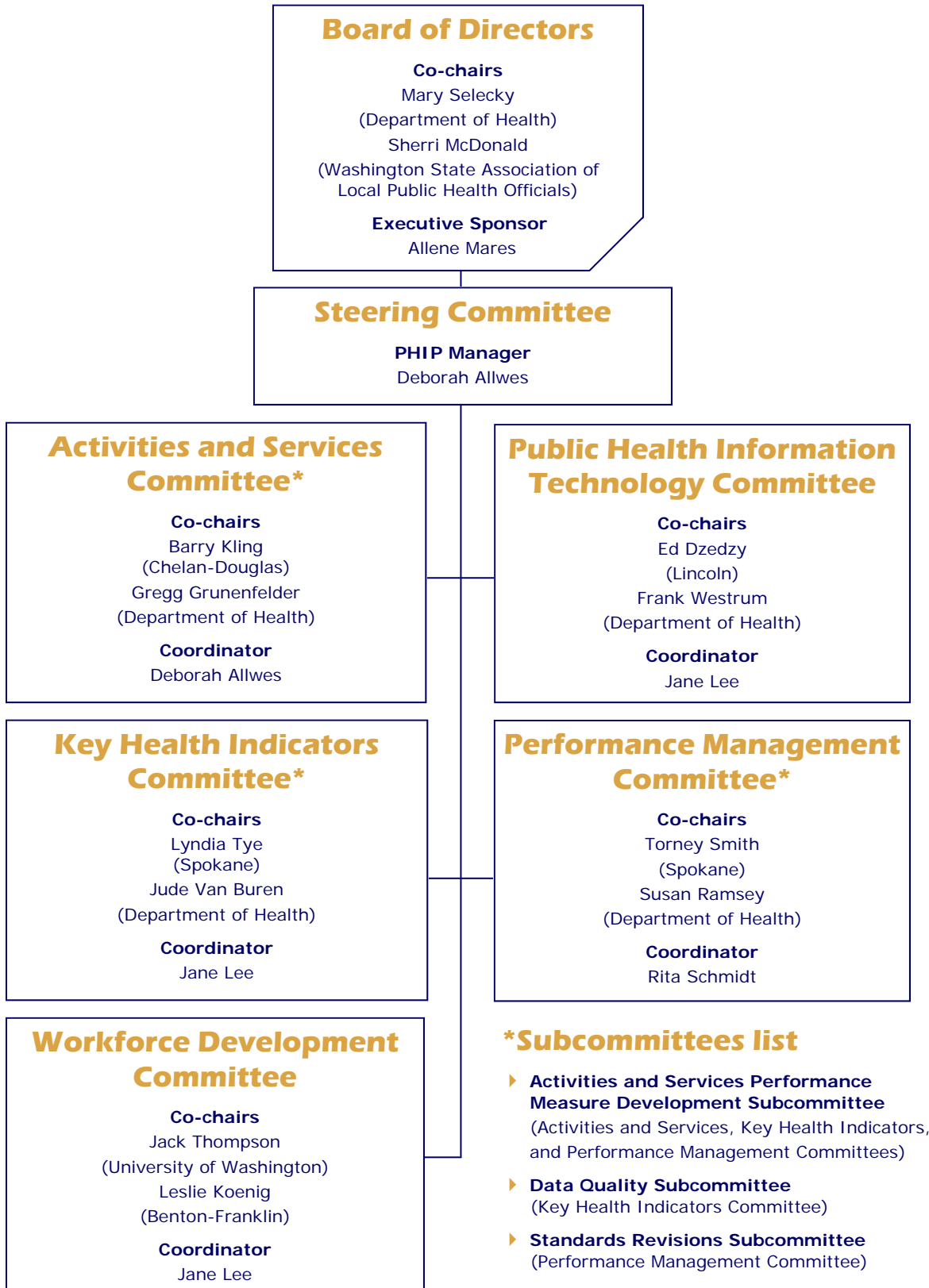


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EXECUTIVE SUMMARY ▶

The Public Health Improvement Plan (the Plan) describes the ways Washington's public health system ensures it can meet the continuing challenge of preventing illness and improving health. It summarizes activities underway throughout the state to assess the capacity of public health agencies and programs, evaluate their effectiveness, and prepare them to meet future challenges.

This work is directed by Washington's Public Health Improvement Partnership (the Partnership), an alliance of experts that provides a guiding vision for public health across Washington.

Part of our vision is to transform Washington's public health system. The Partnership has developed a national model to strengthen the public health system. It accomplishes this goal with practical steps and coordinated activities carried out by local and state public health agencies. This report highlights this work to ensure that our public health system:

- ▶ Is accountable and transparent,
- ▶ Continuously measures and improves outcomes,
- ▶ Supports an adequate number and mix of health care workers to address the needs of each community, and
- ▶ Uses standardized, integrated health information systems.

Like all Plan reports, this 2008 document shows the progress of the work plans of individual committees. It revisits goals and objectives from the previous two years and recommends steps to continue on the path to building a strong and reliable public health system.

A recurring theme of Plan reports since 2002 has been the efforts of Washington's public health leaders to secure reliable and sustainable funding to protect and improve the public's health. In 2008, this element of the Plan's work took on a new urgency. The nation's economic crisis is taking a severe toll on public health agency budgets in Washington and across the United States, causing significant workforce reductions. The National Association of County and City Health Officials estimates that about 7,000 local public health jobs have been lost through layoffs and attrition. (www.naccho.org/advocacy/upload/report_lhdbudgets.pdf)

In Washington, local public health agencies face reduced county revenue, and state government is coping with an unprecedented revenue shortfall as a result of the national economic crisis. Federal funding for public health activities in Washington is also declining.

Over the past six years—beginning long before the current economic problems—the Partnership has directed a review of public health financing and the core

Public Health Improvement Partners

- ▶ American Indian Health Commission
- ▶ Northwest Center for Public Health Practice, University of Washington
- ▶ State Board of Health
- ▶ Washington Health Foundation
- ▶ Washington State Association of Local Public Health Officials
- ▶ Washington State Department of Health
- ▶ Washington State Public Health Association

activities the funds support. The Partnership has developed tools to measure system capacity and performance, health status, and health outcomes. Together, these efforts have confirmed that our state's public health investment can reduce individual suffering from poor health, the burden of disease in communities, and the cost of health care to society.

Recommendations for System-wide Improvement

1. Promote stable and sufficient public health funding to support effective public health services across Washington.

Stable and sufficient funding sources are essential to maintaining a sound public health system. All people in Washington need and expect a predictable level of public health services, regardless of current economic conditions.

2. Continue to build a culture of accountability and quality improvement.

Our public health system builds accountability by continuously measuring its performance and impact on the health of the people in Washington State. Quality improvement is supported by a steady cycle of program reporting, measurement, and evaluation.

Washington is cooperating with other states to develop voluntary accreditation of public health agencies by 2011. Revision of the Standards for Public Health in Washington State should align with the national standards to support state and local agencies in pursuing Public Health Accreditation Board accreditation.

3. Transform the public health system to address the demands of a changing environment.

Our public health system plays a vital role in protecting people from harm

while taking steps to reduce the health impacts of a changing world. The Partnership will set a vision for the future, focus on public health priorities, and direct limited resources where they are critically needed to improve and protect the public's health.

Next Steps for Committees

Just as the Partnership provides general direction for the state's public health system, the committees review objectives for the previous biennium and identify next steps.

The committees whose work is presented in this report are:

- ▶ **Activities and Services**, which provides a statewide platform where the core functions of public health activities are identified, counted, and reported
- ▶ **Key Health Indicators**, which develops and implements ways to measure the health of all who live in Washington
- ▶ **Performance Management**, which directs the development of standards and other activities that address the public health system's capacity, performance, and quality improvement
- ▶ **Public Health Information Technology**, which works to promote public health professionals' access to information that will make their work easier, more efficient, and more effective
- ▶ **Workforce Development**, which ensures that Washington's public health system recruits, retains, and trains an optimal mix of workers.

The individual committee reports on pages 11-23 discuss this work in detail. The following table provides a summary of their accomplishments and next steps:

SUMMARY OF RECOMMENDED NEXT STEPS

The committees have completed most of the objectives set for 2007-2009, with some work continuing to June 2009. The next steps recommended by each committee will form the basis of a work plan for 2009-2011.

Committee Objectives

2007–2009 Completed Objectives	2009–2011 Planned Objectives
<p>Key Health Indicators</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> County data online <input checked="" type="checkbox"/> Funding to collect local data <input checked="" type="checkbox"/> Local assessment tools 	<p>Key Health Indicators</p> <ul style="list-style-type: none"> <input type="checkbox"/> Update Local Public Health Indicators and website <input type="checkbox"/> Provide new communication tools <input type="checkbox"/> Incorporate new indicators
<p>Performance Management</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Training on revised standards <input checked="" type="checkbox"/> Communication, tools on process <input checked="" type="checkbox"/> Self-assessment guide <input checked="" type="checkbox"/> Training on results 	<p>Performance Management</p> <ul style="list-style-type: none"> <input type="checkbox"/> Target system improvements <input type="checkbox"/> Promote and market standards <input type="checkbox"/> Work with states on quality improvement strategies
<p>Workforce Development</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Complete orientation materials <input checked="" type="checkbox"/> Training for 2008 measurement <input type="checkbox"/> Priority training needs 	<p>Workforce Development</p> <ul style="list-style-type: none"> <input type="checkbox"/> Apply standards review results <input type="checkbox"/> Use human resources group list <input type="checkbox"/> Maintain SmartPH
<p>Information Technology</p> <ul style="list-style-type: none"> <input type="checkbox"/> Start coordinated oversight board <input checked="" type="checkbox"/> Best practices, skills training <input checked="" type="checkbox"/> Use business process analysis 	<p>Information Technology</p> <ul style="list-style-type: none"> <input type="checkbox"/> Explore the development of a single, sign-in portal for web-based public health applications <input type="checkbox"/> Develop a PHIT strategic plan
	<p>Activities and Services</p> <ul style="list-style-type: none"> <input type="checkbox"/> Finalize list of core public health services <input type="checkbox"/> Lead service availability survey <input type="checkbox"/> Finalize report to the legislature

INTRODUCTION ▶

This Public Health Improvement Plan report describes the ways Washington's public health system ensures it can meet the continuing challenge of preventing illness and improving health. Published every two years, it summarizes activities underway throughout Washington to assess the capacity of public health agencies and programs, evaluate their effectiveness, and prepare them to meet future challenges.

This work is directed by Washington's Public Health Improvement Partnership, a close alliance of public health experts that provides a guiding vision for Washington's decentralized governmental public health system. It includes 35 local public health agencies, the state Department of Health, and more than 5,400 state and local agency workers.

Partners

- ▶ American Indian Health Commission
- ▶ Northwest Center for Public Health Practice, University of Washington
- ▶ State Board of Health
- ▶ Washington Health Foundation
- ▶ Washington State Association of Local Public Health Officials
- ▶ Washington State Department of Health
- ▶ Washington State Public Health Association

The 2008 Public Health Improvement Plan report presents the progress of the work plans of five committees during the 2007-2009 biennium. This 2008 document revisits goals and objectives from the previous biennium and recommends steps to build a strong and reliable public health system over the next two years and beyond.

For details about committees and their work plans, as well as previous Plan reports, see www.doh.wa.gov/hip.

Everyday in Washington State

- ▶ The state Department of Health, 35 local health agencies, 95 licensed hospitals, and many other partners work together to ensure our communities are prepared for public health emergencies.
- ▶ About 240 babies are born, and the Department of Health's Newborn Screening Program helps them get a healthy start through early detection and prompt care of treatable diseases.
- ▶ More than five million people have safe, reliable drinking water because of the work of Washington's state and local drinking water programs.
- ▶ More than 185,000 women and young children receive healthy food and nutrition education from Women, Infants, and Children programs in their communities.
- ▶ About 50 people call the statewide Tobacco Quit Line (1 800-QUIT-NOW) and take the first step toward quitting smoking.
- ▶ More than 2.5 million people eat in restaurants with confidence thanks to the efforts of local health departments and food safety program staff.
- ▶ About 95% of children entering school are protected against preventable diseases because of public health immunization and education efforts.
- ▶ More than 650 samples are collected locally and tested by the state Public Health Laboratories for diseases such as West Nile virus and influenza.

Source:

Washington State Department of Health

TRANSFORMING AND SECURING OUR PUBLIC HEALTH INVESTMENT ▶

Washington’s Public Health Improvement Partnership leads our state’s effort to transform its public health system. It works to align Washington’s public health policies and programs in ways that emphasize population-based approaches, prevention, and health promotion. It supports policies that encourage healthy environments and lifestyles, protect people and their communities from health threats, and eliminate health disparities.

A transformed public health system would play a key role in achieving a much-improved health system in the United States by emphasizing prevention and good health—with a goal of decreasing the expense of preventable illness and chronic disease.

Since its inception in the mid-1990s, the Plan has been a national model to strengthen the public health system through practical steps and coordinated activities carried out by local and state public health agencies. These activities focus not on illness but on the environmental, social, and behavioral determinants of health. And as described throughout this report, the agencies work together to ensure that our public health system—

- ▶ **Is accountable and transparent**

State and local health officials in Washington have developed and implemented several accountability tools that measure and track system capacity and the health of our state. Among these tools are the Standards for Public Health in Washington State, which define the basic functional expectations of public health agencies, along with process measures that determine whether our system has the capacity to meet them. The Performance Management Committee oversees the standards work. (See page 17.)

- ▶ **Continuously measures and improves outcomes**

The Key Health Indicators Committee oversees different types of measurement of health status—from statewide measures to Local Public Health Indicators that provide a snapshot of the health status, health behavior, and public health system performance of every Washington community. Local public health jurisdictions can use these data to evaluate their work and target community-specific local efforts to improve health. (See page 14.)

- ▶ **Supports an adequate number and mix of health care workers to address the needs of each community**

In 2003, more than 5,400 people worked for Washington’s state and local public health jurisdictions. It is part of their jobs to keep pace with evidence-based policies and interventions. The Workforce Development Committee assists state and local public health jurisdictions in their recruitment of public health workers and supports statewide access to training that would be difficult to obtain without coordinated efforts. (See page 22.)



► **Uses standardized, integrated health information systems**

The Public Health Information Technology Committee encourages access and investment in new technologies that support the need to share information quickly and make timely, data-driven decisions. System-wide planning and investment improves business operations across all of Washington's public health jurisdictions. (See page 20.)

With the leadership of the Partnership and the actions of the state and local public health officials who put these policies into practice, we have made remarkable progress in transforming our public health system. Yet, continued progress—in fact, the very ability of Washington's public health system to perform its fundamental mission—depends on our state securing a long-term, dedicated, and sustainable investment in public health. This has proven an elusive goal, as we discuss in this report.

Investing in Public Health

The Partnership has spent much of the past six years reviewing both public health financing and the core activities supported by that financing. The financing work has revealed an increasingly unstable revenue mix and funding gaps that put the public health system at risk.

We began to study public health financing in 2002. Two years before, public health lost its share of Washington's motor vehicle excise tax. That tax had promised to replace revenues from cities to local public health agencies and provide stable and dedicated resources that would grow over time to account for inflation and population growth. But this revenue source was repealed before it could meet that expectation. The Washington Legislature acted to provide about 90% of the original amount, but inflation has taken a large toll, opening significant gaps in public health resources. Local governments were unable to fill those gaps, and large

funding differences have emerged among communities. In 2007, annual per capita local funding (county general funds to local public health) for local public health agencies ranged from \$1 to nearly \$36. Uneven funding can result in uneven public health protection.

From 1994 to 2004, in the 34 local health jurisdictions outside of King County, total funding from local sources dropped from \$82.7 million to \$60.4 million, a decline of 27%. From 1998 to 2004, Public Health—Seattle & King County's inflation-adjusted funding declined by 19% (when non-grant, non-categorical state and county funding is considered). Studies conducted for the Partnership revealed that local health agencies were operating with only half the resources needed for their services and established the shortfall at close to \$200 million a year statewide.

The legislature has responded to the growing public health financing concerns with special appropriations. In 2005, the legislature created a Joint Select Committee on Public Health Funding to review all public health revenue and expenditures and to "recommend potential sources of future funding." To inform the committee's work, the Washington State Association of Local Public Health Officials, the State Board of Health, and the Washington State Department of Health in 2006 presented a report titled *Creating a Strong Public Health System: Setting Priorities for Action* to the Joint Committee. The report ordered the list of priorities "for the next investment in public health" as:

- Stopping communicable diseases before they spread,
- Reducing the impact of chronic disease,
- Investing in healthy families,
- Protecting the safety of drinking water and air,
- Using health information to guide decisions, and
- Helping people get the health care services they need.

The priorities were grouped within three levels of additional annual investment. According to the report, “The greatest unmet needs are for workers and information tools to help stop the spread of communicable disease, reduce the growing impact of chronic disease, and help support at-risk families and teens to avoid problems.”

The Joint Committee recommended that the state provide “a stable and dedicated funding source” for local public health and called for the state general fund to provide \$50 million per year as an initial step to “mitigate disparities in local jurisdictional core capacity and competence.” The 2007 legislature approved an additional annual investment of \$10 million, which is \$40 million short of the investment recommended by the Joint Committee.

Public health funding is still losing ground.

Promoting Accountability

With the new money, the legislature asked the Department of Health to convene a panel of experts to develop a prioritized list of core public health functions of statewide significance and write performance measures for the new resources.

The Activities and Services Committee has been established to identify the core services local public health jurisdictions perform. It is developing a statewide survey to find a common approach to report and measure the delivery of public health services. In this way, consistent performance measurement can be adopted across the state. And once adopted, these measures will highlight the most effective practices and also signal areas of specific service needs that might vary from one locale to the next. (See page 11.)

To make the best use of the initial \$10 million investment and quantify the impact, a special Performance Measures Committee recommended three measures for every local public health jurisdiction:

1. Increase the uptake of new and under-used child and adolescent vaccines,
2. Improve the timely, complete identification and standard, effective investigation of notifiable conditions (per WAC 246-101), and
3. Develop and implement effective community and health care system interventions to address obesity and its consequent burden of chronic disease.

The Secretary of Health adopted these recommended measures in December 2007. Data collection for the new measures is underway, and the legislature will receive a progress report for the new investment in November 2009.

The Partnership has developed tools to provide accountability for Washington’s public health investment. But our current funding system remains piecemeal and inconsistent. It does not account for population growth, inflation, or a growing workload associated with emerging health threats. We have made tremendous strides in transforming our public health system, but overall investment for public health still falls far short. If these funding issues continue, we risk what we have gained.

In Summary

- ▶ The public health system is under severe strain; overall funding is far short of what public health officials estimate they need to prevent disease and promote health throughout the state.
- ▶ There is a state and local role in financing public health. Funding needs to be logical and sustainable and address population growth, the costs of providing services, local needs, and new and emerging public health threats.
- ▶ Public health has the tools to focus efforts, measure performance, and produce outcomes.

Economic Crisis: The Impact on Public Health

The national economic crisis is taking a severe toll on public health agency budgets in Washington and across the United States, causing already-strapped agencies to operate with significant workforce reductions.

The National Association of County and City Health Officials (NACCHO), which surveyed more than 2,000 local health jurisdictions in late 2008, estimates that “current economic conditions” have already forced a loss—through attrition and layoffs—of about 7,000 public health workers nationwide. More than half (52%) of the local public health agencies responding to the survey reported that they had lost staff in 2008, and close to a third (32%) are planning for layoffs during 2009. In addition, 27% reported that they are operating under a current budget that is less than the previous year, and 44% expect to run smaller budgets next year. Health departments in larger jurisdictions reported the most severe budget pressures. (www.naccho.org/advocacy/upload/report_lhdbudgets.pdf)

In Washington State, local public health jurisdictions face reduced county revenue due to declining county incomes from property and real estate excise taxes and sales tax. State government is coping with an unprecedented revenue shortfall due to a precipitous decline in sales tax revenue. Reductions are also occurring in federal revenue that supports public health activities in Washington.

Local public health agencies are responding by reducing budgets, laying off staff, and cutting programs. Recent gains made in public health preparedness are being lost, and services to families, women, and children are being reduced.

Every effort is being made to preserve core public health work, including prevention efforts, the capacity to track and monitor diseases, and the capacity to protect and improve the public’s health.

The Public Health Improvement Partnership is building on past work to execute a timely response to the economic crisis by—

- ▶ Building a culture of quality improvement,
- ▶ Identifying and redesigning core public health work in response to a rapidly changing environment, and
- ▶ Crafting and applying tools to measure system capacity and performance, health status, and health outcomes.

WORK OF COMMITTEES ▶

ACTIVITIES AND SERVICES COMMITTEE

When the Washington Legislature provided an additional \$10 million a year to local public health agencies as part of E2SSB 5930, it directed the state Department of Health to convene a panel of experts to develop a prioritized list of core public health functions of statewide significance. The list would serve as a framework for a set of performance measures and related reporting by local public health jurisdictions.

The Activities and Services Committee provides a statewide platform where the core functions of public health activities are identified, counted, and reported. One of the greatest challenges the committee has faced since its inception in May 2008 is identifying these core activities in an environment with great geographical diversity, demographic differences, local control, variable resources, and competing local priorities.

The committee has sought input from program experts in local and state public health agencies. Using this information, it drafted a pilot list of core public health activities that public health professionals will review and vet through a series of forums.

Local public health work is complex. Local agencies have conducted their own analyses of the services they perform, but there is no agreement on the core activities of public health and the best way to protect the health of a community. Local activities are closely connected to funding, and without sustained funding, it is difficult to track activities over long periods.

Identifying Core Public Health Activities

The committee will identify core public health activities to inform Washington's public health improvement efforts. A critical part of these efforts is to develop common operational definitions for each service or activity to be counted.

Using activities currently being reported, the committee is identifying and testing ways to count representative activities in each service area and across all local health jurisdictions. The committee has identified the characteristics of activities to include in this initial list. They should be:

- ▶ **Common**

Activities must be delivered by a significant number of local public health agencies, but they don't have to be universal.

- ▶ **Countable**

Activities should be relatively easy to define and count. Examples include restaurant inspections and home visits.



▶ **Non-trivial**

The activities should be significant to public health. For example, a drinking water advisory or outbreak investigation is significant, but the number of meetings attended by staff is not.

▶ **Collected**

Initially, it makes sense to use information already being collected by local public health agencies, the Department of Health, and other agencies.

▶ **Frequent**

The activities should be delivered frequently enough to produce meaningful annual data. For example, responses to major emergencies would not work for this initial set of items because major emergencies occur rarely.

All this effort will support an annual process for local agencies to report counts on public health activities. The committee will contribute to the November 2009 report to the legislature on the additional \$10 million annual investment in public health. Future reports will draw heavily from the work of the Activities and Services Committee. This work will provide a basis for tracking the amount and type of public health activities provided and linking this information to funding levels and health status outcomes.

NEXT STEPS FOR 2009-2011

- ▶ Disseminate the results of interviews with local public health experts about core services.
- ▶ Identify, define, and finalize the list of pilot core public health activities to be counted.
- ▶ Conduct a service availability survey and initial count across local health jurisdictions. Analyze and report on the survey results, including the sustainability of the initial measures.
- ▶ Identify activities that can be measured and develop performance measures (outcomes) on pilot activities.
- ▶ Recommend a tool for annual reporting.
- ▶ Finalize the report to the legislature on this new investment in local public health.

The Public Health Activity Inventory

Public health is focused on outcomes. The public health system is working well when people don't get sick from contaminated water, don't contract communicable diseases, don't develop chronic diseases, don't experience injuries, and aren't exposed to health risks through the air, food, or water.

But such outcomes are only part of the public health story. "Inputs" are another. A community may achieve the desired outcome of preventing waterborne diseases; it achieves this outcome through such inputs as water system inspections. Similarly, communicable diseases may be addressed early through such inputs as immunizations. Although Washington's local public health agencies count inputs, they don't necessarily count the same activities or count them the same way across jurisdictions.

The Activities and Services Committee, as part of implementation of E2SSB 5930, is developing a way to count public health activity inputs consistently and over time. It is compiling a pilot list of core public health activities and the "countable inputs" associated with them. The first stage of this work began in August and September 2008 with interviews of stakeholders from local public health, the Department of Health, and the State Board of Health.

Stakeholders were asked to propose countable activity inputs for major services provided by local public health agencies within core categories. (Six of these categories were outlined in the report *Creating a Strong Public Health System: Setting Priorities for Action*, and a new category for emergency response was added.) For example, immunization is one of the major services associated with the category of communicable disease prevention and response. An activity associated with immunization is direct delivery of vaccines; an example of a countable input is the number of valid doses delivered.

The interviews revealed several challenges to conducting an accurate inventory. Some public health activities with significant impacts on communities are difficult to quantify. Focusing on countable services for the inventory could exclude important public health work, such as building and maintaining partnerships. With Washington's public health system experiencing extreme funding pressure, some stakeholders expressed concern that some of the services they have historically tracked and reported could be downsized or eliminated. Additionally, public health staff expressed the hope that additional work be streamlined by using activities that are already tracked and reported.

The pilot inventory is being reviewed in a series of meetings of public health officials and health policy makers throughout the state, in part to reduce the list to a manageable size and to reduce the burden on local agencies by leveraging existing reporting. The committee is also working to align the list with Washington's public health performance measures and nationally recognized core functions.

KEY HEALTH INDICATORS COMMITTEE

One of the primary challenges of the Partnership is to frame ways to ask the question, “How healthy are we?” The answers come in the form of health outcomes—measurements of health status and the underlying determinants of health. For several years, the Key Health Indicators Committee has explored ways to address this question, including a state health report card.

The committee’s newest health measurement undertaking is the list of 32 Local Public Health Indicators, a measurement of how each jurisdiction is progressing toward improving health outcomes. These indicators provide a snapshot of health status, health behavior, and public health system performance at the local level. Along with the Standards for Public Health in Washington State, the indicators represent a new tool to measure system performance through the general health of Washington’s population. They also allow for comparisons of health status across Washington counties and with state and national averages. And like the standards, the Local Public Health Indicators are designed to recognize the unique socio-demographic context that contributes to every community’s health problems and the effectiveness of public health programs in responding to them.

The Key Health Indicators Committee and the Performance Management Committee worked together to identify the indicators, selecting measures that are valid, reliable, and accessible. The first set of 27 Local Public Health Indicators, along with local, state, and national comparisons, were posted on a new website in October 2007. Five indicators will have data available in 2009, including three environmental health indicators, a children’s health insurance indicator, and a child immunization indicator.

The Public Health Improvement Partnership has arranged for training sessions for local public health agencies to use the

data to evaluate work and prioritize activities. It has also developed toolkits to help local public health jurisdictions integrate the Local Public Health Indicators with other performance and quality improvement measures, including the standards.

These efforts are helping staff of local agencies put the indicators to work. A survey conducted in 2008 by the Key Health Indicators Committee showed that the top three uses of the indicators were to identify or confirm a health issue, for planning processes, and for community education. In addition, 73% of those asked about their use of the local indicators reported that they had plans to work on health issues identified by the indicators, and 89% have already used them in their work or plan to do so. Many staff expressed interest in how their local jurisdiction compared to the state as a whole, and others reported that they had shared local indicator data with local boards and community groups.

The Local Public Health Indicators will be re-evaluated after completion of two, two-year reporting cycles. One cloud in the future of the indicators—as well as other data collection activities that help measure health status—is the rising cost of conducting the Behavioral Risk Factor Surveillance System (BRFSS) survey. The survey is the source of county-level data for 17 of the 32 local indicators.



Local Public Health Indicators

Communicable Disease

- ▶ Reported Chlamydia infections
- ▶ Treated Chlamydia infections
- ▶ Influenza vaccine (65 years or older)
- ▶ Children's immunization status*

Prevention and Health Promotion

- ▶ Years of healthy life expected at age 20
- ▶ Adult cigarette smoking
- ▶ Adult physical activity
- ▶ Adults overweight/obese
- ▶ Adult fruit/vegetable consumption
- ▶ Adult binge drinking
- ▶ Adults with diabetes
- ▶ Adult poor mental health

Environmental Health*

- ▶ Solid waste facilities in compliance
- ▶ Food establishments with critical violations
- ▶ On-site sewage systems, corrective actions

Maternal and Child Health

- ▶ First trimester prenatal care
- ▶ Maternal cigarette smoking
- ▶ Teen birth rate
- ▶ Low birth weight
- ▶ Teen physical activity
- ▶ Teen cigarette smoking
- ▶ Teens overweight
- ▶ Teen alcohol use
- ▶ Childhood unintentional injury hospitalizations

Access to Care

- ▶ Adults with unmet medical need
- ▶ Adults with personal health care provider
- ▶ Adult dental care
- ▶ Adult preventive cancer screening—breast
- ▶ Adult preventive cancer screening—cervical
- ▶ Adult preventive cancer screening—colorectal
- ▶ Adults with health insurance
- ▶ Children with health insurance*

* Under development

NEXT STEPS FOR 2009-2011

- ▶ In 2009 update the Local Public Health Indicators website with the second two-year cycle of data and "populate" five indicators with data as they become available.
- ▶ Provide new communication tools about the indicators to local health agencies.
- ▶ Following completion of the second two-year data cycle in 2009, the committee will work with local health jurisdictions and the Department of Health to review the current set of indicators and consider other health indicators that are part of county and state health data sets, including serious health events.
- ▶ Identify clear and sustainable funding for the collection of BRFSS data.

Local public health agencies and their boards of health can use Local Public Health Indicators data to compare the health of their jurisdictions with other communities and with the state of Washington as a whole. The graphic below—with a sample Local Public Health Indicator—shows how.

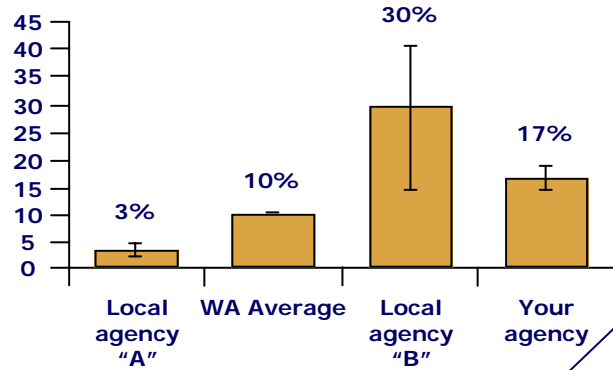
Indicator: Maternal cigarette smoking

Percent of women giving birth who smoked at any time during pregnancy—data are from the birth certificate

Rationale: Tobacco smoking during pregnancy is the most important preventable cause of low birth weight.

[Chart template—use to develop a chart for any indicator]

Example: Percent of women giving birth who smoked at any time during pregnancy* 2003-2005



*Birth certificates—crude percent

PERFORMANCE MANAGEMENT COMMITTEE

One of the most ambitious features of the public health improvement laws that the Washington Legislature passed during the mid-1990s was to direct the state's public health system to develop standards of performance and measure its ability to meet them over time.

The Standards for Public Health in Washington State, required by RCW 43.70.520, are process measures that evaluate the performance of Washington's public health system by defining public health services that communities need and measuring the capacity of public health agencies to provide them. The Performance Management Committee directs the development of the standards and other activities that address system capacity, performance, and quality improvement.

More than a decade of intense work has been invested in the standards to craft a practical and reliable tool to use across state and local public health agencies. Originally drafted in the late 1990s, they have undergone a field test (2000), a baseline study (2002), a first measurement (2005), and a significant revision in 2006. During 2008, the 12 revised standards were used to measure system performance. The results of the 2008 standards assessment are summarized on page 19 and in Appendix 3.

The 2008 review provided a snapshot of system performance and revealed areas of challenge. In this and other performance reviews, the reviewers have collected examples of exemplary practices that are shared on a website (www.doh.wa.gov/hip/documents/PerfMgmt/O8EP/EPcompendium.pdf). The review also provided both a report for each county and an overall report that shows strengths and strategies for improvement.

The assessment showed that since the 2005 review, the Department of Health

and local public health agencies have made significant improvements in system performance. In addition, reviewers concluded that Washington's public health system works as well as it does because of the skills of public health staff and their commitment to improve the health of all who live in Washington.

Grant Activities

Washington's public health standards work has drawn wide attention as an innovative strategy for public health system performance improvement. The National Network of Public Health Institutes, which works with the Centers for Disease Control and Prevention to strengthen public health infrastructure, has recognized this effort by three times awarding Washington a Robert Wood Johnson Foundation grant to use performance management and standards to improve the quality of public health programs.

The Performance Management Committee provides oversight of this grant, which supports such activities as:

- ▶ Targeting areas of focus for system improvement based on the performance reviews and committing to a schedule for the reviews (every three years),
- ▶ Promoting and marketing the standards to the public health workforce,



- ▶ Working with other states to complete quality improvement projects including immunizations and chronic disease prevention to improve public health outcomes, and
- ▶ Developing tools to teach staff quality improvement tools and strategy.

Accreditation Efforts

Another area where the committee is working closely with other states is in the growing national effort to improve the effectiveness of public health agencies through voluntary accreditation.

Much of the momentum for accreditation work originated with a 2003 report of the federal Institute of Medicine, *The Future of the Public's Health in the 21st Century*, which called for a national steering committee to study the benefits of accrediting public health agencies across organizational structures and jurisdictions. A year later, the national Exploring Accreditation Project drafted a model voluntary program whose scope was consistent with the Standards for Public Health in Washington State, including

- ▶ Monitoring health status and understanding health issues,
- ▶ Protecting people from health problems and hazards,
- ▶ Giving people the information they need to make healthy choices, and
- ▶ Helping people receive the health services they need.

In 2007, a private, non-profit Public Health Accreditation Board (PHAB) received start-up funding from the Centers for Disease Control and Prevention, the Robert Wood Johnson Foundation, the U.S. Health Resources and Services Administration, and several public health groups. PHAB is developing national accreditation for local, state, tribal, and territorial health departments by 2011. The process will involve use of standards and measures, site visit reviews, and performance documentation and scoring—all methods that are similar to those used in Washington State's standards review process.

Washington is one of 16 states participating in the Multi-state Learning Collaborative, which works to enhance performance activities underway in each state and share exemplary practices to achieve accreditation and system improvement.

NEXT STEPS FOR 2009-2011

- ▶ Revise the Standards for Public Health in Washington State and accompanying measures to align with national, Public Health Accreditation Board standards.
- ▶ Continue to monitor system performance measures and use the results to identify priority areas for system improvements by 2011.
- ▶ Provide training and communicate regularly about the use of the standards.
- ▶ Develop an evaluation plan of the standards process.

Meeting Standards for Performance

Washington State's 12 Standards for Public Health describe the functions that public health agencies should be able to perform; the 162 associated measures (76 for local agencies and 86 for state agencies) describe how to meet them. The Public Health Improvement Partnership has established a three-year cycle to review how well Washington's state and local public health agencies are meeting the standards. In 2008, this work occurred during March through May, as reviewer teams measured performance against the standards at all 35 local health jurisdictions, 19 Department of Health program sites, the Office of the Secretary of Health, and the State Board of Health.

An overall systems report presents aggregated data from all the site visits (see www.doh.wa.gov/philp/PerfMgmt/07stds/doc/08SysRep.pdf and Appendix 3 to this report). It shows that for all the standards:

- ▶ Local public health agencies were able to demonstrate performance in 56% of the local measures;
- ▶ The state Board of Health and the Department of Health were able to demonstrate performance in 71% of the state measures.

The following table shows how local public health agencies performed for each of the standards:

Standard		Demonstrates	Partly Demonstrates	Does Not Demonstrate
1.	Community Health Assessment	78%	14%	8%
2.	Communication	83%	14%	3%
3.	Community Involvement in Data Review	41%	32%	28%
4.	Monitoring Public Health Threats	83%	13%	4%
5.	Responding to Emergencies	50%	31%	19%
6.	Prevention and Health Education	50%	33%	17%
7.	Addressing Gaps/Health Services	57%	30%	13%
8.	Program Planning and Evaluation	34%	31%	35%
9.	Financial Management Systems	35%	54%	11%
10.	Human Resource Systems	58%	28%	14%
11.	Information Systems	50%	36%	13%
12.	Leadership and Governance	34%	38%	29%

The next table summarizes performance on the standards for the Department of Health and the state Board of Health:

Standard		Demonstrates	Partly Demonstrates	Does Not Demonstrate
1.	Community Health Assessment	86%	12%	2%
2.	Communication	88%	12%	0%
3.	Community Involvement in Data Review	77%	21%	3%
4.	Monitoring Public Health Threats	80%	20%	0%
5.	Responding to Emergencies	33%	63%	3%
6.	Prevention and Health Education	79%	20%	1%
7.	Addressing Gaps/Health Services	67%	26%	8%
8.	Program Planning and Evaluation	63%	27%	10%
9.	Financial Management Systems	37%	47%	16%
10.	Human Resource Systems	59%	38%	3%
11.	Information Systems	45%	50%	5%
12.	Leadership and Governance	75%	25%	0%

PUBLIC HEALTH INFORMATION TECHNOLOGY COMMITTEE

Public health needs technology to operate as a “system.” The Public Health Information Technology Committee oversees technology planning across many separate public health entities so that communication and data transfer systems are compatible, reliable, secure, and cost-effective. The goal is for public health professionals to have access to information that will make their work easier, more efficient, and more effective.

The committee works to overcome a significant challenge for the public health system’s use of technology: the fact that every local health jurisdiction has its own information infrastructure, which is usually a part of a county system. The committee studies ways to adopt system-wide advancements in technology, ensuring coordination across all public agencies, avoiding duplication of effort and stand-alone applications, and assuring that training needs are met.

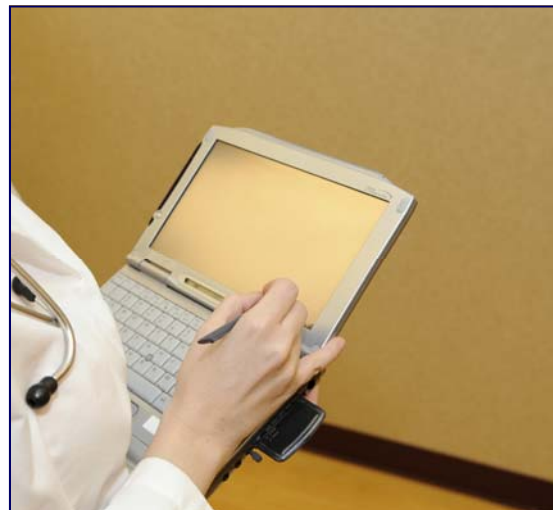
A New Tool for Health Assessment

Providing timely information on the health of communities is one of the most important functions of the public health system. In 2005, representatives from across Washington’s public health system worked together to explore the business needs and community requirements for a new method of community health assessment. The work included an examination of software options and costs, and its outcome was the Community Health Assessment Tool.

The assessment tool, known as CHAT, supports the collection, analysis, interpretation, and sharing of information about the health status and needs of the population. Currently in its design and costing stage, this tool is a hybrid of two current data systems that are being used by Washington’s public health agencies: VistaPHw and EpiQMS. It will eventually include the datasets and functionality necessary to meet future data needs. The first release of CHAT is scheduled for August 2009. The second release, scheduled for August 2010, will include additional applications for enhanced statistical and mapping functions.

Improving Emergency Response

The Public Health Information Technology Committee is taking a fresh look at long-term business practice needs of the Washington State Secure Electronic Communication, Urgent Response, and Exchange System (WASECURES). This web-based instrument allows local and state public health agencies to send and receive emergency notifications and collaborate with partners quickly and securely. WASECURES participants include all of Washington’s state and local public



health agencies, emergency response agencies in Oregon and British Columbia, the Centers for Disease Control and Prevention, and the U.S. Department of Health and Human Service.

Public health workers throughout Washington can use WASECURES to contact each other day or night, through the web, voice mail, e-mail, and text messaging. The system provides a way for the Department of Health and the Centers for Disease Control and Prevention to distribute time-sensitive information to state, local public health, and emergency response workers. WASECURES stores shared public health documents that can be used for preparedness training and emergency response.

Information Technology Training

To ensure an efficient workforce, workers need basic computer skills. In 2008, the Public Health Information Technology Committee was once again able to offer funding in the form of mini-grants to local public health agencies and Indian tribes for computer-related training. The funds support instruction to improve basic technology skills and to facilitate access to hundreds of online information technology courses. Seven local health jurisdictions and two tribes will receive funds to purchase learning aids, bring instructors on-site, and send staff to instructor-led courses.

NEXT STEPS FOR 2009-2011

- ▶ Explore the development of a single sign-in portal for web-based public health applications to find and manage data more effectively.
- ▶ Develop a Public Health Information Technology strategic plan, possibly including an oversight board, to improve software coordination among all public health agencies.

WORKFORCE DEVELOPMENT COMMITTEE

More than 5,400 people work for Washington's local and state public health agencies. They come from diverse backgrounds to implement the common mission of protecting and improving the health of people in our state. The Workforce Development Committee oversees two sets of activities to ensure that the workforce performs at an optimal level: recruiting and retaining an effective mix of workers and providing the training and educational opportunities that are essential to their job performance.

Both tasks require attention to the needs of individual agencies and to the public health system as a whole. As Washington's communities fall more deeply into recession, the committee must address the needs of workers who are feeling growing pressures from resource cuts and layoffs.

New Recruitment Strategies

Beginning with publication of *Everybody Counts*, an enumeration of Washington's public health workforce published in 2003, the Workforce Development Committee sponsored a series of studies about the people who work in public health, what attracts them to this field, and the barriers they face in performing their jobs. A study, contained in the *Employee Recruitment and Retention in Local Health Jurisdictions in Washington State* report, examined hiring issues through interviews with administrators and directors of local public health jurisdictions and compared these to other states. A report called *Qualitative Investigation: Recently Hired Public Health Employees* assessed hiring barriers in public health.

In December 2007, the committee developed a recruitment and retention plan to promote careers in public health, assist

local public health agencies with recruitment tips, and identify ways to encourage careers in public health. These resources are shown on the committee's website. (www.doh.wa.gov/phip/wfd/resources/category/RRS.htm)

The committee will direct implementation of several recommendations from the recruitment plan. These include encouraging public health professionals to talk about the variety of public health careers at universities and colleges, integrating public health in health sciences curriculum, and sending speakers to high schools and other community settings to talk about public health. Key to this outreach is the ability to describe the work of public health. The committee's website maintains updated links to orientation materials, including videos.

To attract the most qualified recruits to Washington's public health system, the committee is working with the Washington State Public Health Association to cast a wide net. It has sponsored a national online recruitment tool, the American Public Health Association (APHA) CareerMart, and placed a link to it on the Washington State Public Health Association's website. The site enables all public health agencies and members of the Partnership to advertise their public health jobs widely, assists job seekers in



applying for positions, and tracks people who have both viewed advertisements and applied for positions. From August 2007 through July 2008 the site posted 360 public health jobs in Washington. (www.wspha.org/Employment-job.htm)

Online Training

Ensuring access to professional development is one of the Workforce Development Committee's primary responsibilities. This has proven to be particularly demanding during this period of tightening local and state resources.

Across Washington, a growing number of public health professionals are making use of the statewide learning management system called SmartPH. This online learning tool, created to assist with training workers in emergency preparedness, has evolved into an all-purpose learning management system. It continues to add new and updated courses along with content for system training, evaluation, and quality improvement. SmartPH offers training plans that issue continuing education credits. In 2008 alone, the system added four epidemiology and communicable disease investigation courses.

In many parts of Washington, SmartPH is filling a professional development gap caused by severe training reductions. But it also brings challenges:

- ▶ Some agencies experience internal technology issues that block access to SmartPH.
- ▶ Some users experience difficulties with the learning management system.
- ▶ Because of budget pressures, the Department of Health will have less ability to enhance SmartPH through creating and updating courses.

The committee received considerable guidance on workforce training needs from the 2008 performance review of the Standards for Public Health in Washington State. Taken together, the workforce development measures revealed inconsistent performance in such areas as emergency preparedness training, annual performance evaluations with individual training plans, and availability of training sessions for all employees.

NEXT STEPS FOR 2009-2011

- ▶ Continue to review local and state results from the 2008 assessment of the Standards for Public Health in Washington State as they relate to training needs.
- ▶ Explore ways to use a distribution list to share information, tips, and strategies for recruitment and retention across local agencies.
- ▶ Continue to maintain SmartPH use and user satisfaction through ongoing new user and refresher trainings, system evaluation, complaint review, promotion of system capacity, training plans, and matching of courses to identified needs and competencies.
- ▶ Monitor national accreditation in public health activities for workforce development issues.

RECOMMENDATIONS AND NEXT STEPS ▶

Every two years, Washington's Public Health Improvement Partnership revisits its strategies, measures progress toward its goals, and recommends further steps to strengthen and improve the public health system.

Following are the Partnership's recommendations for a strong and reliable public health system during the 2009-2011 biennium and beyond:

1. **Promote stable and sufficient public health funding to support effective public health services across Washington.**

Stable and sufficient funding sources are essential to maintaining a sound public health system. All people in Washington need and expect a predictable level of public health services, regardless of current economic conditions.

2. **Continue to build a culture of accountability and quality improvement.**

Our public health system builds accountability by continuously measuring its performance and impact on the health of the people in Washington State. Quality improvement is supported by a steady cycle of program reporting, measurement, and evaluation.

Washington is cooperating with other states to develop voluntary accreditation of public health agencies by 2011. Revision of the Standards for Public Health in Washington State should align with the national standards to support state and local agencies in pursuing Public Health Accreditation Board accreditation.

3. **Transform the public health system to address the demands of a changing environment.**

Our public health system plays a vital role in protecting people from harm while taking steps to reduce the health impacts of a changing world. The Partnership will set a vision for the future, focus on public health priorities, and direct limited resources where they are critically needed to improve and protect the public's health.

NEXT STEPS FOR COMMITTEES

Just as the Partnership reviews its overall goals for Washington's public health system, the committees revisit their objectives for the previous biennium and identify next steps.

The current work plans of committees are discussed in detail on pages 11-23. Following are all the committees' recommendations for 2009-2011:



Activities and Services Committee

- ▶ Disseminate the results of interviews with local public health experts about core services.
- ▶ Identify, define, and finalize the list of pilot core public health activities to be counted.
- ▶ Conduct a service availability survey and initial count across local health jurisdictions. Analyze and report on the survey results, including the sustainability of the initial measures.
- ▶ Identify activities that can be measured and develop performance measures (outcomes) on pilot activities.
- ▶ Recommend a tool for annual reporting.
- ▶ Finalize the report to the legislature on this new investment in local public health.

Key Health Indicators Committee

- ▶ In 2009 update the Local Public Health Indicators website with the second two-year cycle of data and “populate” five indicators with data as they become available.
- ▶ Provide new communication tools about the indicators to local health agencies.
- ▶ Following completion of the second two-year data cycle in 2009, the committee will work with local health jurisdictions and the Department of Health to review the current set of indicators and consider other health indicators that are part of county and state health data sets, including serious health events.
- ▶ Identify clear and sustainable funding for the collection of BRFSS data.

Performance Management Committee

- ▶ Revise the Standards for Public Health in Washington State and accompanying measures to align with national, Public Health Accreditation Board standards.
- ▶ Continue to monitor system performance measures and use the results to identify priority areas for system improvements by 2011.
- ▶ Provide training and communicate regularly about the use of the standards.
- ▶ Develop an evaluation plan of the standards process.

Public Health Information Technology Committee

- ▶ Explore the development of a single, sign-in portal for web-based public health applications to find and manage data more effectively.
- ▶ Develop a Public Health Information Technology strategic plan, possibly including an oversight board, to improve software coordination among all public health agencies.

Workforce Development Committee

- ▶ Continue to review local and state results from the 2008 assessment of the Standards for Public Health in Washington State as they relate to training needs.
- ▶ Explore ways to use a distribution list to share information, tips, and strategies for recruitment and retention across local agencies.
- ▶ Continue to maintain SmartPH use and user satisfaction through ongoing new user and refresher trainings,

system evaluation, complaint review, promotion of system capacity, training plans, and matching of courses to identified needs and competencies.

- ▶ Monitor national accreditation in public health activities for workforce development issues.

The following table summarizes how the committees met their objectives for 2007-2009 and matches these objectives with the ones they set for 2009-2011.

SUMMARY OF RECOMMENDED NEXT STEPS

The committees have completed most of the objectives set for 2007-2009, with some work continuing to June 2009. The next steps recommended by each committee will form the basis of a work plan for 2009-2011.

Committee Objectives

2007–2009 Completed Objectives	2009–2011 Planned Objectives
<p>Key Health Indicators</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> County data online <input checked="" type="checkbox"/> Funding to collect local data <input checked="" type="checkbox"/> Local assessment tools 	<p>Key Health Indicators</p> <ul style="list-style-type: none"> <input type="checkbox"/> Update Local Public Health Indicators and website <input type="checkbox"/> Provide new communication tools <input type="checkbox"/> Incorporate new indicators
<p>Performance Management</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Training on revised standards <input checked="" type="checkbox"/> Communication, tools on process <input checked="" type="checkbox"/> Self-assessment guide <input checked="" type="checkbox"/> Training on results 	<p>Performance Management</p> <ul style="list-style-type: none"> <input type="checkbox"/> Target system improvements <input type="checkbox"/> Promote and market standards <input type="checkbox"/> Work with states on quality improvement strategies
<p>Workforce Development</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Complete orientation materials <input checked="" type="checkbox"/> Training for 2008 measurement <input type="checkbox"/> Priority training needs 	<p>Workforce Development</p> <ul style="list-style-type: none"> <input type="checkbox"/> Apply standards review results <input type="checkbox"/> Use human resources group list <input type="checkbox"/> Maintain SmartPH
<p>Information Technology</p> <ul style="list-style-type: none"> <input type="checkbox"/> Start coordinated oversight board <input checked="" type="checkbox"/> Best practices, skills training <input checked="" type="checkbox"/> Use business process analysis 	<p>Information Technology</p> <ul style="list-style-type: none"> <input type="checkbox"/> Explore the development of a single, sign-in portal for web-based public health applications <input type="checkbox"/> Develop a PHIT strategic plan
	<p>Activities and Services</p> <ul style="list-style-type: none"> <input type="checkbox"/> Finalize list of core public health services <input type="checkbox"/> Lead service availability survey <input type="checkbox"/> Finalize report to the legislature

APPENDICES ▶

- ▶ Appendix 1: Public Health Improvement Laws
- ▶ Appendix 2: History of Local Public Health Funding in Washington State
- ▶ Appendix 3: Overall System Performance Report Summary

APPENDIX 1: PUBLIC HEALTH IMPROVEMENT LAWS ▶

RCW 43.70.512

Public Health—Required Measurable Outcomes

- (1) Protecting the public's health across the state is a fundamental responsibility of the state. With any new state funding of the public health system as appropriated for the purposes of *sections 60 through 65 of this act, the state expects that measurable benefits will be realized to the health of the residents of Washington. A transparent process that shows the impact of increased public health spending on performance measures related to the health outcomes in subsection (2) of this section is of great value to the state and its residents. In addition, a well-funded public health system is expected to become a more integral part of the state's emergency preparedness system.
- (2) Subject to the availability of amounts appropriated for the purposes of *sections 60 through 65 of this act, distributions to local health jurisdictions shall deliver the following outcomes:
 - (a) Create a disease response system capable of responding at all times;
 - (b) Stop the increase in, and reduce, sexually transmitted disease rates;
 - (c) Reduce vaccine preventable diseases;
 - (d) Build capacity to quickly contain disease outbreaks;
 - (e) Decrease childhood and adult obesity and types I and II diabetes rates, and resulting kidney failure and dialysis;
 - (f) Increase childhood immunization rates;
 - (g) Improve birth outcomes and decrease child abuse;
 - (h) Reduce animal-to-human disease rates; and
 - (i) Monitor and protect drinking water across jurisdictional boundaries.
- (3) Benchmarks for these outcomes shall be drawn from the national healthy people 2010 goals, other reliable data sets, and any subsequent national goals.

[2007 c 259 § 60.]

RCW 43.70.514

Public Health—Definitions

The definitions in this section apply throughout *sections 60 through 65 of this act unless the context clearly requires otherwise.

- (1) "Core public health functions of statewide significance" or "public health functions" means health services that:

- (a) Address: Communicable disease prevention and response; preparation for, and response to, public health emergencies caused by
pandemic disease, earthquake, flood, or terrorism; prevention and management of chronic diseases and disabilities; promotion of healthy families and the development of children; assessment of local health conditions, risks, and trends, and evaluation of the effectiveness of intervention efforts; and environmental health concerns;
- (b) Promote uniformity in the public health activities conducted by all local health jurisdictions in the public health system, increase the overall strength of the public health system, or apply to broad public health efforts; and
- (c) If left neglected or inadequately addressed, are reasonably likely to have a significant adverse impact on counties beyond the borders of the local health jurisdiction.

- (2) "Local health jurisdiction" or "jurisdiction" means a county board of health organized under chapter 70.05 RCW, a health district organized under chapter 70.46 RCW, or a combined city and county health department organized under chapter 70.08 RCW.

[2007 c 259 § 61.]

RCW 43.70.516

Public Health—Department's Duties

- (1) The department shall accomplish the tasks included in subsection (2) of this section by utilizing the expertise of varied interests, as provided in this subsection.
 - (a) In addition to the perspectives of local health jurisdictions, the state board of health, the Washington health foundation, and department staff that are currently engaged in development of the public health services improvement plan under RCW 43.70.520, the secretary shall actively engage:
 - (i) Individuals or entities with expertise in the development of performance measures, accountability and systems management, such as the University of Washington school of public health and community medicine, and experts in the development of evidence-based medical guidelines or public health practice guidelines; and

- (ii) Individuals or entities who will be impacted by performance measures developed under this section and have relevant expertise, such as community clinics, public health nurses, large employers, tribal health providers, family planning providers, and physicians.
 - (b) In developing the performance measures, consideration shall be given to levels of performance necessary to promote uniformity in core public health functions of statewide significance among all local health jurisdictions, best scientific evidence, national standards of performance, and innovations in public health practice. The performance measures shall be developed to meet the goals and outcomes in RCW 43.70.512. The office of the state auditor shall provide advice and consultation to the committee to assist in the development of effective performance measures and health status indicators.
 - (c) On or before November 1, 2007, the experts assembled under this section shall provide recommendations to the secretary related to the activities and services that qualify as core public health functions of statewide significance and performance measures. The secretary shall provide written justification for any departure from the recommendations.
- (2) By January 1, 2008, the department shall:
- (a) Adopt a prioritized list of activities and services performed by local health jurisdictions that qualify as core public health functions of statewide significance as defined in RCW 43.70.514; and
 - (b) Adopt appropriate performance measures with the intent of improving health status indicators applicable to the core public health functions of statewide significance that local health jurisdictions must provide.
- (3) The secretary may revise the list of activities and the performance measures in future years as appropriate. Prior to modifying either the list or the performance measures, the secretary must provide a written explanation of the rationale for such changes.
- (4) The department and the local health jurisdictions shall abide by the prioritized list of activities and services and the performance measures developed pursuant to this section.
- (5) The department, in consultation with representatives of county governments, shall provide local jurisdictions with financial incentives to encourage and increase local investments in core public health functions. The local jurisdictions shall not supplant existing local funding with such state-incented resources.

[2007 c 259 § 62.]

RCW 43.70.518 Public Health—Annual Reports

Beginning November 15, 2009, the department shall report to the legislature and the governor annually on the distribution of funds to local health jurisdictions under *sections 60 through 65 of this act and the use of those funds. The initial report must discuss the performance measures adopted by the secretary and any impact the funding in chapter 259, Laws of 2007 has had on local health jurisdiction performance and health status indicators. Future reports shall evaluate trends in performance over time and the effects of expenditures on performance over time.

[2007 c 259 § 63.]

***Reviser's note:** "Sections 60 through 65 of this act" include this section, RCW 43.70.512, 43.70.514, 43.70.516, and 43.70.522, and the 2007 c 259 amendments to RCW 43.70.520

RCW 43.70.520 Public Health Services Improvement Plan— Performance Measures

- (1) The legislature finds that the public health functions of community assessment, policy development, and assurance of service delivery are essential elements in achieving the objectives of health reform in Washington state. The legislature further finds that the population-based services provided by state and local health departments are cost-effective and are a critical strategy for the long-term containment of health care costs. The legislature further finds that the public health system in the state lacks the capacity to fulfill these functions consistent with the needs of a reformed health care system. The legislature further finds that public health nurses and nursing services are an essential part of our public health system, delivering evidence-based care and providing core services including prevention of illness, injury, or disability; the promotion of health; and maintenance of the health of populations.
- (2) The department of health shall develop, in consultation with local health departments and districts, the state board of health, the health services commission, area Indian health service, and other state agencies, health services providers, and citizens concerned about public health, a public health services improvement plan. The plan shall provide a detailed accounting of deficits in the core functions of assessment, policy development, assurance of the current public health system, how additional

public health funding would be used, and describe the benefits expected from expanded expenditures.

- (3) The plan shall include:
 - (a) Definition of minimum standards for public health protection through assessment, policy development, and assurances:
 - (i) Enumeration of communities not meeting those standards;
 - (ii) A budget and staffing plan for bringing all communities up to minimum standards;
 - (iii) An analysis of the costs and benefits expected from adopting minimum public health standards for assessment, policy development, and assurances;
 - (b) Recommended strategies and a schedule for improving public health programs throughout the state, including:
 - (i) Strategies for transferring personal health care services from the public health system, into the uniform benefits package where feasible; and
 - (ii) Linking funding for public health services to performance measures that relate to achieving improved health outcomes; and
 - (c) A recommended level of dedicated funding for public health services to be expressed in terms of a percentage of total health service expenditures in the state or a set per person amount; such recommendation shall also include methods to ensure that such funding does not supplant existing federal, state, and local funds received by local health departments, and methods of distributing funds among local health departments.
- (4) The department shall coordinate this planning process with the study activities required in section 258, chapter 492, Laws of 1993.
- (5) By March 1, 1994, the department shall provide initial recommendations of the public health services improvement plan to the legislature regarding minimum public health standards, and public health programs needed to address urgent needs, such as those cited in subsection (7) of this section.
- (6) By December 1, 1994, the department shall present the public health services improvement plan to the legislature, with specific recommendations for each element of the plan to be implemented over the period from 1995 through 1997.
- (7) Thereafter, the department shall update the public health services improvement plan for presentation to the legislature prior to the beginning of a new biennium.
- (8) Among the specific population-based public health activities to be considered in the public health services improvement plan are: Health data assessment and chronic and infectious disease surveillance; rapid response to

outbreaks of communicable disease; efforts to prevent and control specific communicable diseases, such as tuberculosis and acquired immune deficiency syndrome; health education to promote healthy behaviors and to reduce the prevalence of chronic disease, such as those linked to the use of tobacco; access to primary care in coordination with existing community and migrant health clinics and other not for profit health care organizations; programs to ensure children are born as healthy as possible and they receive immunizations and adequate nutrition; efforts to prevent intentional and unintentional injury; programs to ensure the safety of drinking water and food supplies; poison control; trauma services; and other activities that have the potential to improve the health of the population or special populations and reduce the need for or cost of health services.

[2007 c 259 § 64; 1993 c 492 § 467.]

RCW 43.70.522

Public Health Performance Measures—Assessing the Use of Funds—Secretary’s Duties

- (1) Each local health jurisdiction shall submit to the secretary such data as the secretary determines is necessary to allow the secretary to assess whether the local health jurisdiction has used the funds in a manner consistent with achieving the performance measures in RCW 43.70.516.
- (2) If the secretary determines that the data submitted demonstrates that the local health jurisdiction is not spending the funds in a manner consistent with achieving the performance measures, the secretary shall:
 - (a) Provide a report to the governor identifying the local health jurisdiction and the specific items that the secretary identified as inconsistent with achieving the performance measures; and
 - (b) Require that the local health jurisdiction submit a plan of correction to the secretary within sixty days of receiving notice from the secretary, which explains the measures that the jurisdiction will take to resume spending funds in a manner consistent with achieving the performance measures. The secretary shall provide technical assistance to the local health jurisdiction to support the jurisdiction in successfully completing the activities included in the plan of correction.
- (3) Upon a determination by the secretary that a local health jurisdiction that had previously been identified as not spending the funds in a manner consistent with achieving the performance measures has resumed consistency, the secretary shall notify the governor that the jurisdiction has returned to consistent status.

- (4) Any local health jurisdiction that has not resumed spending funds in a manner consistent with achieving the performance measures within one year of the secretary reporting the jurisdiction to the governor shall be precluded from receiving any funds appropriated for the purposes of *sections 60 through 65 of this act.
- (5) Funds may resume once the local health jurisdiction has demonstrated to the satisfaction of the secretary that it has returned to consistent status.

[2007 c 259 § 65.]

RCW 43.70.580 Public Health Improvement Plan—Funds—Performance- based Contracts—Rules— Evaluation and Reports

The primary responsibility of the public health system, is to take those actions necessary to protect, promote, and improve the health of the population. In order to accomplish this, the department shall:

- (1) Identify, as part of the public health improvement plan, the key health outcomes sought for the population and the capacity needed by the public health system to fulfill its responsibilities in improving health outcomes.
- (2) (a) Distribute state funds that, in conjunction with local revenues, are intended to improve the capacity of the public health system. The distribution methodology shall encourage system-wide effectiveness and efficiency and provide local health jurisdictions with the flexibility both to determine governance structures and address their unique needs.

- (b) Enter into with each local health jurisdiction performance-based contracts that establish clear measures of the degree to which the local health jurisdiction is attaining the capacity necessary to improve health outcomes. The contracts negotiated between the local health jurisdictions and the department of health must identify the specific measurable progress that local health jurisdictions will make toward achieving health outcomes. A community assessment conducted by the local health jurisdiction according to the public health improvement plan, which shall include the results of the comprehensive plan prepared according to RCW 70.190.130, will be used as the basis for identifying the health outcomes. The contracts shall include provisions to encourage collaboration among local health jurisdictions. State funds shall be used solely to expand and complement, but not to supplant city and county government support for public health programs.

- (3) Develop criteria to assess the degree to which capacity is being achieved and ensure compliance by public health jurisdictions.
- (4) Adopt rules necessary to carry out the purposes of chapter 43, Laws of 1995.
- (5) Biennially, within the public health improvement plan, evaluate the effectiveness of the public health system, assess the degree to which the public health system is attaining the capacity to improve the status of the public's health, and report progress made by each local health jurisdiction toward improving health outcomes.

[1995 c 43 § 3.]

APPENDIX 2: HISTORY OF LOCAL PUBLIC HEALTH FUNDING IN WASHINGTON STATE

Structure and Authority

Washington State law gives primary responsibility for the health and safety of Washington residents to 39 county governments. It charges the counties' legislative authorities with establishing either a county department or a health district to assure the public's health. (RCW 70.05, 70.08, 70.46—www.leg.wa.gov/lawsandagencyrules) In Washington State the governmental public health system consists of 35 local public health agencies that work with the state Department of Health. In three cases, county legislative authorities have formed multi-county health districts.

Each county legislative authority must also establish a local board of health, which "shall have supervision over all matters pertaining to the preservation of the life and health of the people within its jurisdiction." (RCW 70.05.060) Local boards of health approve the budgets, programs, and policies of local public health agencies and may also appoint the agency administrator. Board members include county commissioners or members of the county council and may include elected or non-elected officials. Elected officials must always make up the majority.

Historically, a combination of local, state, and federal resources has financed local public health services. These include:

- ▶ Local funds—county general funds, licenses, permits, and fees for services,
- ▶ State funds—contracts for specific programs, flexible funds to meet local needs, and reimbursement for performing specific services (i.e., Medicaid reimbursement),
- ▶ Federal funds—contracts for specific programs and reimbursement for performing specific services (most of this funding is passed through the state Department of Health), and
- ▶ Other funding—such as federal or private grants.

The mix of these funds and the conditions attached to their use have changed over time.

Local Funding—Past to Present

When tuberculosis (TB) was more common, in the mid-1900s, a portion of local property taxes was set aside for tuberculosis control and general public health. As TB declined, more of the funds were available for general public health. In 1976, the Washington Legislature repealed the requirement that those funds be spent on public health, leaving the cities and counties to determine spending levels for public health. Local government continued to collect the tax but could use it for another purpose.

While counties held the major responsibility for public health, the law made reference to cities as well, without stipulating the amount of cities' financial participation. In practice, not all cities provided funding for public health. Over time, local governments made very different choices, and per capita public health spending came to vary widely from one jurisdiction to another.

Most local funding is derived from county contributions from taxes, fees, or other local sources. With no criteria set for local government contribution, the variation is

pronounced. Data for 2007 reveal that local government funding to most public health agencies ranged from just over \$1 to nearly \$36 per capita, per year. (www.doh.wa.gov/msd/OFS/2007rs/Revsum07.htm)

In 1993 the legislature passed the Health Services Act, which shifted 2.95% of motor vehicle excise tax (MVET) revenues from cities to counties for use by local public health departments and districts. This change effectively removed the statutory responsibility for cities to fund public health. It also clarified that counties were responsible and made clear that no city could establish its own health department. This portion of the law was to take effect in 1996. (Some cities continue to contribute to public health, but funding is generally tied to specific services and residence requirements.)

The amount of MVET revenue to be raised by the 2.95% fell roughly \$7 million short of what cities had collectively contributed. The legislature provided a special appropriation to make up most of the difference in the years that followed. The idea was that MVET revenues were growing, so the gap would be filled in time and public health would once again have a dedicated source of revenue that kept pace with population growth and inflation.

The distribution of the MVET funds was somewhat problematic. Since MVET funding had been tied to city contributions, the money for each county was linked to the level of past city contributions. This perpetuated the historical variation among jurisdictions.

Following voter approval of the tax-limiting Initiative 695, the legislature in 2000 voted to repeal the MVET. The stability of a dedicated funding source was gone. During the same session, the legislature appropriated an amount from state

general fund that restored 90% of the lost public health funds. During the 2001 session, the legislature again made up 90% of the difference and has made an equal appropriation—without adjustments for inflation or population growth—in each biennium since.

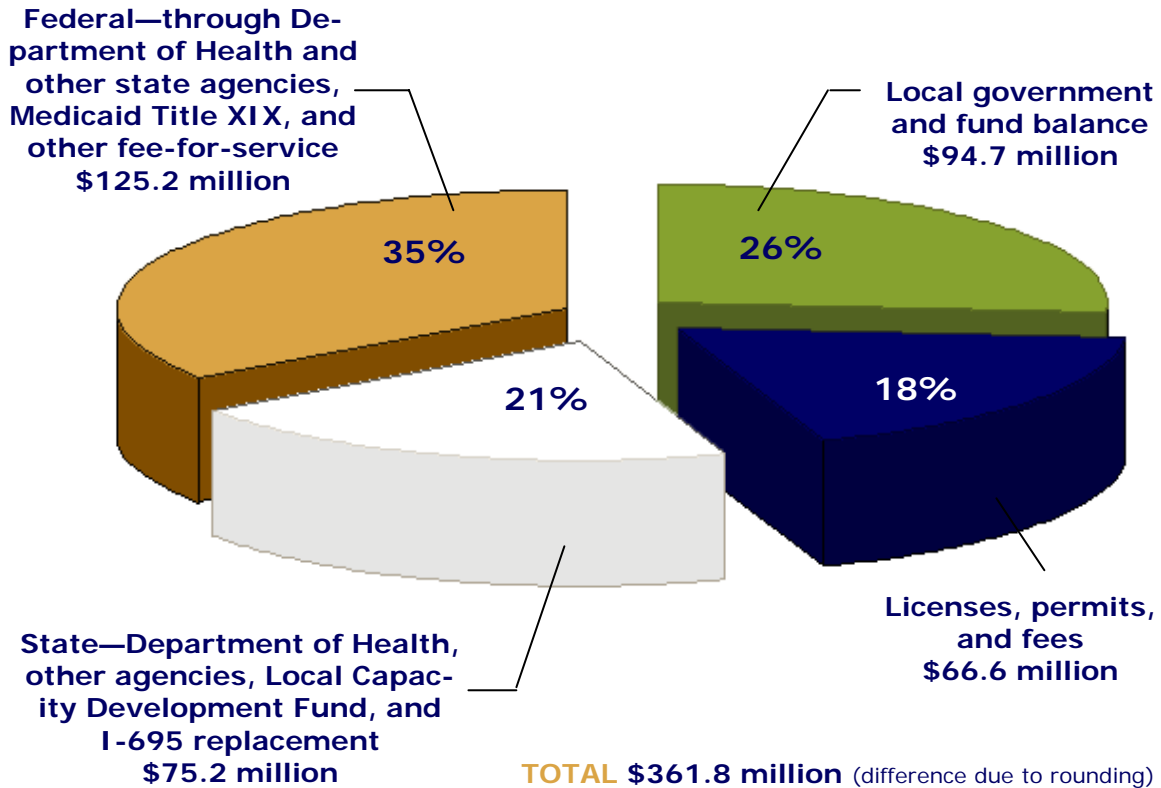
Categorical Funding

Local public health agencies receive both federal and state funds, generally through contracts with the Washington State Department of Health and the Department of Social and Health Services. Most often, these are “categorical funds” because they are restricted to specific programs, including the Women, Infants, and Children (WIC) nutritional program; family planning; HIV services; tobacco use prevention; obesity prevention and physical activity and nutrition promotion; drinking water quality; and solid and hazardous waste programs.

Local public health agencies can be over-reliant on categorical funds, particularly when local resources decline. Recognizing this problem, the 1993 Health Services Act directed the use of state general funds to establish the Local Capacity Development Fund (LCDF). This fund supports locally determined needs and priorities. Washington’s 1993-1995 biennial budget appropriated \$10 million in what was characterized as a “down payment” toward an estimated need for \$115 million a year for local public health. In 1995, the LCDF was increased to \$16 million for the next biennium. No further legislative increases were made toward this fund, and during an economic downturn in 1999-2001, the fund was reduced by \$700,000.

The current funding streams supporting local public health are shown in the following chart:

Total Funding for Local Public Health Washington, 2007



Source: 2007 Revenue Summary from BARS A Reports,
Compiled by the Department of Health

State and federal funding often comes with special conditions such as distribution formulas, target populations, or other mandates. The Department of Health and each local public health agency develop a consolidated contract every five years that is amended as needed. The contract for each local agency includes the program requirements and deliverables.

Funding Needs vs. Funded Levels

Since the mid-1990s, the Public Health Improvement Partnership has supported a series of studies that have identified the gap between what was currently funded and what was actually needed to fully fund public health services. One study revealed that in the decade of 1994 to 2004, local public health funding dropped

27%—from \$82.7 million to \$60.4 million for 34 local public health jurisdictions (excluding King County).

Inflation is a significant factor in this decline. For example, the LCDF amounts and the MVET replacement amounts stayed the same. Each year, the loss to inflation seems small, but since 2003, the state population has increased by 8% and the consumer price index has increased by 17%.

The 2006 Washington Legislature created the Joint Select Committee on Public Health Funding, a bipartisan study committee of the House and Senate, to address the persistent public health funding shortfall. In response to the committee's request for information, local and state public health officials developed and presented a report titled *Creating a Stronger Public Health System: Setting Priorities for Action* (labeled Statewide Priorities on the committee's web site). The report ordered a list of priorities "for the next investment in public health" as follows:

- ▶ Stopping communicable diseases before they spread,
- ▶ Reducing the impact of chronic disease,
- ▶ Investing in healthy families,
- ▶ Protecting the safety of drinking water and air,
- ▶ Using health information to guide decisions, and
- ▶ Helping people get the health care services they need.

The committee unanimously concluded that "the lack of a stable source of funding provided specifically for public health services has eroded the ability of local

health jurisdictions to maintain a reliable statewide system that protects the public's health." It recommended that the state "provide additional funding in the amount of approximately \$50 million annually during the 2007-2009 biennium, as an initial investment" and that a "dedicated account for public health revenues" be established. Finally, it recommended that these actions be considered "the first step in what must be continuing state and local efforts to fund the public health system at a level that provides the capacity to effectively deliver the five core functions." (www.leg.wa.gov/Joint/Committees/PHF)

The 2007 Washington Legislature appropriated an additional \$10 million annually for local public health during the 2007-2009 biennium (E2SSB 5930). The so-called "5930 funds" go to local agencies to address the priority areas of stopping communicable diseases before they spread and reducing the impact of chronic disease. Public health officials have developed statewide performance measures for each. The measures are improved uptake of childhood immunizations, more timely communicable disease investigation, and efforts to stop the obesity epidemic. Local public health agencies are using these funds for new and additional activities in their communities that are deemed to have the greatest potential to affect these performance measures. Currently, there is no mechanism in this funding stream to account for inflation, population growth, or new and additional public health responsibilities.

As of July 1, 2007, three state, non-categorical funding streams support local public health agencies as shown in the following table:

Non-categorical Funds to Local Public Health Agencies

Year Initiated	Amount	Name	Source
1993	\$16 million/ biennium	Local Capacity Development Fund	State General Fund
2000	\$48 million/ biennium	Motor Vehicle Excise Tax or I-695 replacement	State General Fund
2007	\$20 million/ biennium	5930 funds (named after the bill number that created the fund)	State General Fund

Summary

Washington's public health system depends on funding from local, state, and federal sources. Since the 1970s, cities and counties have had responsibility for determining spending levels for public health. Per capita local public health spending varies widely across jurisdictions. The system has lacked the stability of a dedicated funding source since 2000, and legislative appropriations since have not adjusted for inflation and population growth. Local public health

agencies have relied somewhat on categorical federal and state funding streams. Several studies directed by the Public Health Improvement Partnership have identified the growing gap between current resources and those required to fully fund public health services. Recognizing the shortfall, the 2007 Washington Legislature appropriated an additional \$10 million annually for local public health during the 2007-2009 biennium.

APPENDIX 3: 2008 PERFORMANCE REVIEW OF STANDARDS FOR PUBLIC HEALTH IN WASHINGTON STATE—Executive Summary of OVERALL SYSTEM REPORT ▶

The Standards

This report provides summary results of the 2008 performance review of the Standards for Public Health in Washington State. The standards were developed collaboratively by local and state public health staff in 1999 and have been used every three years to review the public health system in Washington. A baseline measurement was conducted in 2002 and re-measurements were conducted in 2005 and 2008.

Providing a framework for public health and laying the foundation of “what every person has the right to expect,” the standards are an integral part of measuring and improving public health practice. While the standards describe the functions that public health agencies should be able to perform, the measures describe how the standard is met. For the 2008 standards review cycle, there are 12 standards and 162 measures (76 local measures and 86 state measures). Because of differing roles, there is a set of measures for local health agencies and a separate set for the state agencies and programs, including the State Board of Health and the Department of Health.

The standards reside under the auspices of the Public Health Improvement Partnership’s (PHIP) Performance Management Committee. The committee, with assistance of a consultant team from MCPP Healthcare Consulting, Inc., was responsible for directing and overseeing the standards review process and approving the recommendations put forward in this report.

Site Visit Preparation and Process

Eight performance reviewers—two from local health agencies and six from the Department of Health—were trained in 2007 to conduct portions of the site review for the performance standards. In the fall of 2007 the MCPP consultants provided 11 half-days of training for Department of Health and local health agency staff and managers to help them prepare for the performance review.

Site reviews were conducted from March through May 2008. Each site review concluded with a closing conference in which general strengths and opportunities for improvement were discussed, and feedback on the standards and assessment process was obtained. In total, 34 local

Standards for Public Health

1. Community Health Assessment
2. Communication
3. Community Involvement
4. Monitoring and Reporting Threats
5. Planning for Emergencies
6. Prevention and Education
7. Addressing Critical Health Services
8. Program Planning and Evaluation
9. Financial and Management Systems
10. Human Resource Systems
11. Information Systems
12. Leadership and Governance

health agencies, the State Board of Health, and 20 Department of Health program sites were reviewed.

Program Reviews

While the 12 standards apply to all public health programs/activities conducted at the state or local level, not all measures under a standard apply to all programs/activities. Consequently, there are three ways a measure can apply—first, to the agency at the local or state level (rather than individual programs), second, to every program/activity (individual demonstration), or third, to specific programs/activities.

During the 2008 standards review cycle, specific local health agency programs were reviewed. These same programs were reviewed at the Department of Health to create a system-wide “look” at these programs. Programs were selected because of heightened activity or interest in these programs.

Comparison to the 2005 Review

Comparability of previous topic areas to performance in the individual standards in the 2008 review is not possible. This is because the standards were restructured and significantly revised in 2006, with the focus of the individual standards on a specific area of public health practice. However, some comparisons were still possible for findings specific to individual measures, and analysis for statistically significant change was conducted on about two dozen measures.

The 2008 review necessitated a higher level of performance because the standards were revised to clarify and further stipulate the requirements of each measure. The results must be interpreted with the understanding that performance was, in some cases, more challenging to demonstrate.

Overall System Performance

Three common themes can be drawn from the 2008 snapshot of system performance. First, 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 Washington State residents. Second, since the 2005 performance review, the Department of Health and some local health agencies made significant investments to address the results of the 2005 performance review and to improve the public health system. Third, many of the local and Department of Health programs were only able to partially demonstrate performance due to failure in completing the Plan-Do-Study-Act (PDSA) cycle of improvement (e.g., planning activities and implementing them, but not studying the effectiveness or impact of the activities or taking action on the results).

Overall Performance Findings

In this report there is a focus on the 50th percentile, in which the midpoint is envisioned as a fulcrum. Where the weight falls toward demonstrated performance, improvement may still be needed, but the system is heading in the right direction. Conversely, where the weight falls towards no or partially demonstrated performance, these areas will require significant planning and assistance to fully demonstrate performance.

The State Board of Health and Department of Health agencies and programs were able to demonstrate an average of 71% of the measures in all the standards. Three standards had more than 50% of the state-level agencies and programs able to demonstrate performance on every measure, and one standard had three measures with fewer than 50% of programs able to demonstrate performance. There were 42 measures with 95% or higher demonstrated performance.

Local health agency results showed an overall performance ranging from 24% to 83% of measures demonstrated by individual local health agency. Average demonstrated performance was 56% of all local health agency measures. Compared to the percent of demonstrated measures in 2005, 14 local health agencies increased the percent of measures they were able to demonstrate and 17 decreased in percent demonstrated. There were no measures where no local health agency was able to demonstrate performance.

Findings Specific to the Standards

Overall for local health agencies, the aggregate level of fully demonstrates is at or above 75% in three of the standards, while five standards have an aggregate fully demonstrates score between 50% and 74%. Four standards have less than 50% fully demonstrates—Standards 3, 8, 9, and 12.

During the 2008 standards review cycle, specific local health agency programs were reviewed. These same programs were reviewed at the Department of Health to create a system-wide “look” at these programs. Programs were selected because of heightened activity or interest in these programs.

For all state programs, the aggregate level of fully demonstrates is at or above 75% in six of the standards, while three standards have an aggregate fully demonstrates score between 50% and 74%. Three standards have less than 50% fully demonstrates—Standards 5, 9, and 11.

Relationship of Performance to Annual Budgets and Number of Employees

As in previous standards review cycles, analysis was conducted to determine if, and what, correlations exist between

performance of the standards and both budget and FTE levels in local jurisdictions. As expected, some jurisdictions with larger budgets or more FTEs did demonstrate higher performance of some of the measures. In other words, more resources did lead to higher performance. However, the relationship between overall local health agency performance and annual budgets and FTEs did not show a clear correlation between the size of the local health agency and the demonstrated performance. There is variability in performance that indicates that performance, while connected to budget and size, also has other drivers.

Recommendations

Recommendations are made to assist local and state agencies in developing meaningful approaches to address deficiencies and capitalizing on opportunities.

Closing the Plan-Do-Study-Act Cycle

Many of the local and state programs were only able to partially demonstrate performance due to a failure to complete the Plan-Do-Study-Act (PDSA) cycle of improvement (e.g., planning activities and implementing them, but not studying the effectiveness or impact of the activities or taking action on the results of monitoring program performance measures). Several recommendations related to specific areas that need “closure of the PDSA loop” are described below.

Overall Recommendation: *Management and evaluation processes should emphasize the Study step of the PDSA cycle, and the Act step should be emphasized in leadership and governance minutes and reports.*

Community Involvement in the Review of Data and Recommending Action

Standard 3 showed lower performance for measures that relate to the review and use of data to inform community

recommendations for action and use of the Study and the Act steps of the PDSA improvement cycle.

Recommendation for Standard 3: *Routinely document community group and stakeholder review of data along with the actions taken to address conclusions from the data analysis, including policy decisions based on the review of data.*

Process to Identify New Licensees

Both local health agency and Department of Health programs showed lower performance due to the inconsistency in processes to identify new licensees. Most of the local health agencies have a process for distributing notifiable conditions information to providers, but many do not have processes to identify the new licensees in their communities.

Recommendation for Standard 4: *Local and state programs should work collaboratively to implement actions to provide the notifiable conditions information to new licensees in a timely manner.*

Emergency Preparedness and Response Plan (EPRP) Orientation and Training

This measure had low performance in 2005 and again across the public health system in this 2008 review.

Recommendation for Standard 5: *Local health agencies and the Department of Health should consistently orient new staff to the EPRP and conduct annual review of the EPRP for all staff in the agency.*

Review of Prevention and Health Education Information

Certain measures require the review of all types of educational materials at least every other year. This was another area with low performance in 2005 as well as this performance review.

Recommendation for Standard 6: *Implement systematic processes for the regular review of materials to revise or improve them, as needed.*

Program Planning and Evaluation

While more agencies and programs at both the state and local level demonstrated the establishment of program goals, objectives and performance measures than in 2005, this is still a system-wide area needing improvement. This standard continues to have the lowest level of performance (34% demonstrated) at the local level as demonstrated through the review of 100 programs. In the Department of Health programs, the performance in several measures showed meaningful improvement, but more than 25% were not able to demonstrate the tracking, analysis, and use of monitoring performance measures. Improvement efforts should be expanded by:

▶ **Establishing and Monitoring Performance Measures and Using the Results**

Measures for this standard are a prime arena to demonstrate “closing the PDSA loop” by tracking, analyzing and using program specific performance measures. There are numerous examples of exemplary practices at both the local and state level that should be used by lower performing programs to improve.

Recommendation 1 for Standard 8: *All programs in local health agencies and the Department of Health strengthen their focus and initiatives to establish and monitor performance measures and use the results to improve programs and services.*

▶ **Conducting at Least Annual Internal Audits of Cases or Activities**

Only about 25% of the Department of Health programs and less than 20% of local programs were able to demonstrate that they conduct annual audits of program activities for timeliness and compliance with protocols.

Recommendation 2 for Standard 8: *Conduct internal audits of regular activities in all programs, such as case files or investigation reports, for timeliness and compliance with protocols and procedures.*

Customer Service Standards

Measures require that customer service standards be established for all employees that interact with the public, stakeholders and/or partners and that measures for these standards be identified and evaluated. At the local level, only 24% of local health agencies were able to demonstrate that they had established and evaluated customer service standards for those staff that interact with the public. The Department of Health agency partially demonstrated this measure.

Recommendation 3 for Standard 8: *Establish customer service standards for all staff that interact with the public and identify and monitor performance measures for these standards.*

Performance Evaluations with Training Plans

Measures require that performance evaluations are conducted routinely and include training plans that are updated annually. This measure was partially demonstrated by the Department of Health agency, and only 18% of local health agencies were able to demonstrate the measure.

Recommendation for Standard 10: *Ensure that performance evaluations, including plans for training and development, are conducted annually for all staff.*

Standards Needing the Most Improvement in Local Health Agencies

Several standards had low aggregate performance with 50% or fewer local health agencies able to demonstrate performance. These four areas offer the most urgent need for improvement across all local health agencies:

- ▶ Standard 3 related to community involvement in review of data and taking action
- ▶ Standard 8 related to program planning and evaluation
- ▶ Standard 9 related to ensuring budgets are aligned with strategic plans and to conducting contract monitoring
- ▶ Standard 12 related to board of health functions, strategic planning, and quality improvement activities

Recommendation for Standard 12:

- ▶ *Address requirements for board of health for orientation, operating rules, and review of data and taking action*
- ▶ *Establish and get board of health approval of an agency strategic plan*
- ▶ *Establish a quality improvement plan by using the results of monitoring performance measures and program evaluations and implement quality improvement plan*

Standards Needing the Most Improvement in the Department of Health

Several standards had low aggregate performance with 50% or fewer of the Department of Health agency or programs able to demonstrate performance. These three areas offer the most urgent need for improvement across the Department of Health:

- ▶ Standard 5 related to technical assistance and consultation and orientation and training on planning for and responding to public health emergencies
- ▶ Standard 9 related to legal review of contracts and to conducting contract monitoring
- ▶ Standard 11 related to data sharing agreements and protected data transfers

Recommendations for the Next Performance Improvement and Review Cycle

The cycle of performance improvement that begins with the release of the 2008 Overall System Performance Report must take into consideration the standards and processes established by the Public Health Accreditation Board (PHAB) for national accreditation. Revision of the Washington Standards for Public Health should align, to the extent possible, with the PHAB standards to support state and local agencies in pursuing national PHAB accreditation in the future.

Recommendation:

- ▶ *Establish a subcommittee of the Performance Management Committee to revise the Washington Standards for Public Health based on the feedback from the review cycle and to align, to the extent possible, with the PHAB standards for accreditation. Ensure these revisions to the standards are reflected in a revision of the guidelines. The standards revision work should be completed in 2009.*
- ▶ *Plan to conduct the next performance review cycle in 2011 using the revised standards to create the overall system report of statewide public health performance. Use site-specific reports as a tool to prepare local and state agencies interested in applying for PHAB accreditation.*

- ▶ *Involve and engage boards of health in increasing knowledge of their role in demonstrating performance against the standards and in relationship to future PHAB accreditation.*

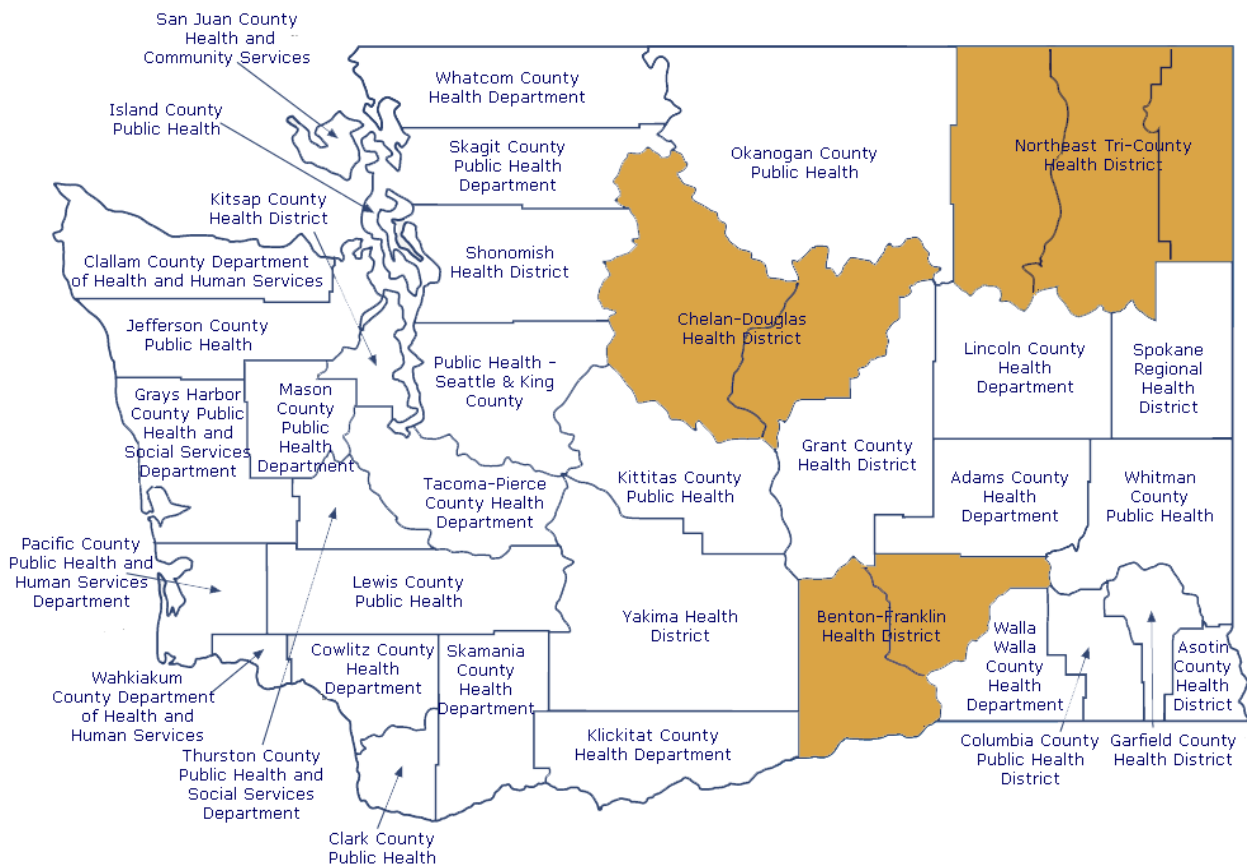
In June 2008, following the performance review, a survey was created and sent to all participants in the review process. Using a Likert and forced-choice scale, participants were asked to rate their experience in demonstrating performance against the revised standards in the training provided prior to the site visit and during the site visit. The survey also requested information on the methods and staff used to prepare for the performance review. This information will be used to make improvements to the standards and the review processes.

Another aspect of the performance review is the site-specific reports that are provided to each LHJ, the SBOH and the DOH agency and programs. These reports provide specific recommendations for improving deficient areas based on the findings at each individual site. Each agency and program is encouraged to create quality improvement plans and efforts around these vital recommendations. Likewise, the Performance Management Committee will be reviewing this Overall System Performance Report's recommendations and taking action to implement quality improvement efforts across the state's public health system.

(The 2008 Overall System Report in its entirety can be found at www.doh.wa.gov/philp/PerfMgmt/07stds/doc/08SysRep.pdf)

Washington's Governmental Public Health System

- ▶ 35 local public health jurisdictions, three with multiple counties
- ▶ Washington State Department of Health and other state agencies
- ▶ Washington State Board of Health



PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND
HEALTHIER WASHINGTON