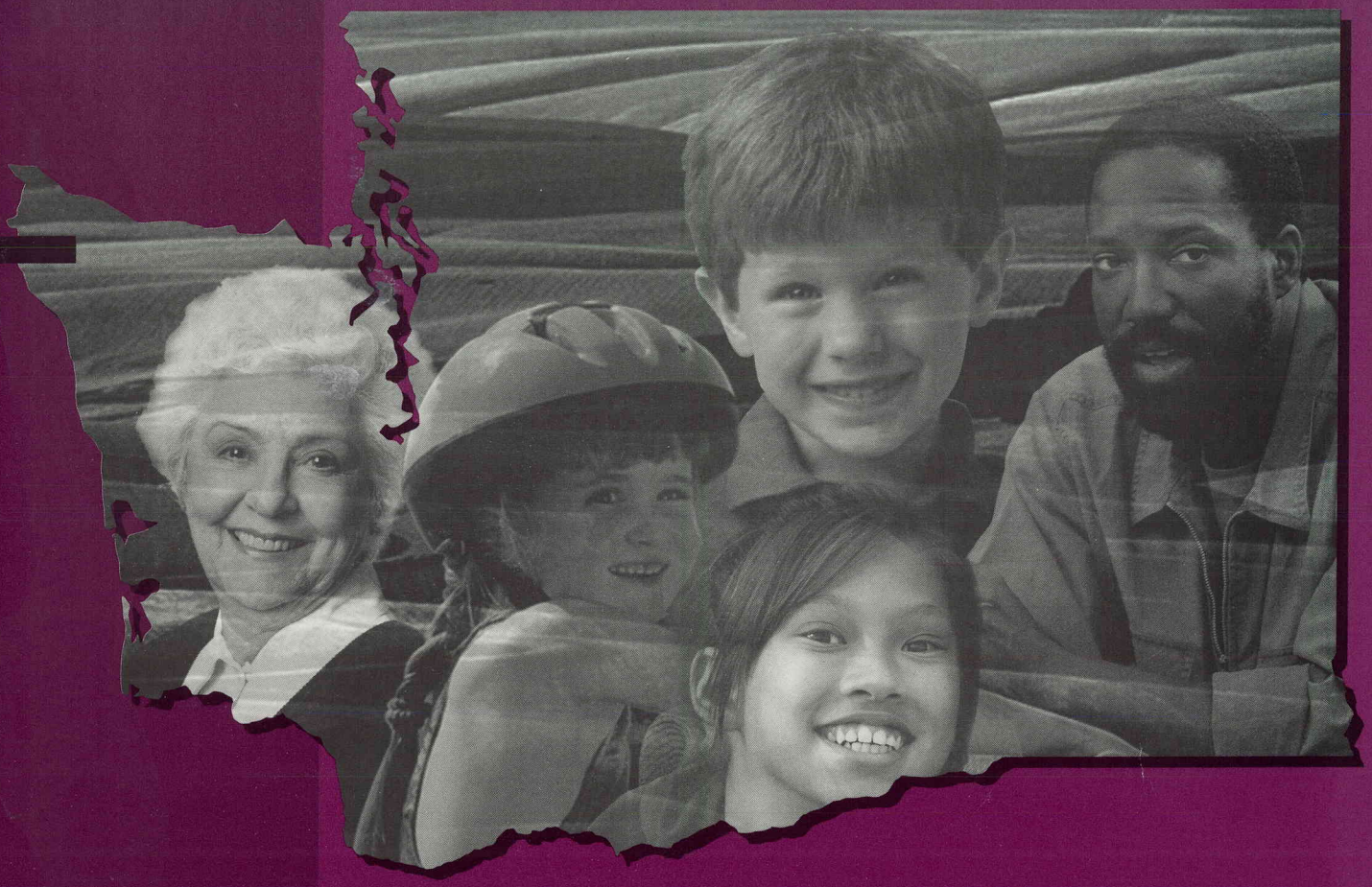
2000 Public Health Improvement Plan



2000

Key Concepts in Public Health

The Core Functions of Public Health

Public health officials cannot protect the health of their communities effectively if they focus only on individual programs, diseases, or threats. They must be prepared for new health problems that emerge. The core functions approach helps health departments and their communities prepare for new health threats and other emerging issues. Washington State has used this approach in planning for public health system improvements by making the system more responsive to changing needs. Following is a summary of how the core functions work.

Health Assessment

Helps us determine how, where, and when health threats are occurring. It includes collection, analysis, and dissemination of information on health status, incidence of health problems and risks, choices about health behavior, environmental health concerns, availability and quality of services, and the concerns of individuals.

Policy Development

Used to set a course for specific action or regulation to improve or protect health. It may involve a formal public process, as with a local Board of Health. Private organizations and citizen groups also develop policy.

Assurance

Means making sure the right things happen—that we have the health information we need, that we adhere to the policies we have chosen, and that needed services are available. Government programs often play an assurance or oversight role, but they do not provide all the needed services. The public health system depends on the combined efforts of many private, community-based, and public agencies.

Ten Essential Services of Public Health

Assessment

- Monitor health status of the community.
- Diagnose and investigate health problems and hazards.
- Inform and educate people about health issues.

Policy Development

- Mobilize partnerships to solve community problems.
- Support policies and plans to achieve health goals.

Assurance

- Enforce laws and regulations to achieve health goals.
- Link people to needed personal health services.
- Ensure a skilled public health workforce.
- Evaluate effectiveness, accessibility, and quality of health services.
- Research and apply innovative solutions.

Proposed Standards for Public Health in Washington

For the past decade, Washington State has used the federally developed "Core Functions" and the "Ten Essential Services of Public Health" as a foundation for our work on public health improvement. These concepts are incorporated into our Proposed Standards for Public Health. The Standards themselves, are organized into five categories:

- Protecting people from disease
- Understanding health issues
- Assuring a safe, healthy environment
- Prevention is best: promoting healthy living
- Helping people get the services they need

2000 Public Health Improvement Plan

December 2000

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Northwest Center for Public Health Practice, University of Washington School of Public Health and Community Medicine

Washington State Board of Health

Washington State Association of Local Public Health Officials

Washington State Department of Health

December 1, 2000

I am proud to present the *2000 Public Health Improvement Plan*. Please think of this as more than just words on a page. It is a living and breathing plan: a commitment to continue the important work of finding ways to improve the health of the people of Washington State.

Over the past century, our average life expectancy has improved by 30 years. Public health advances are directly responsible for most of those gains. Advances in areas such as immunization, food safety, and public education about healthy lifestyles are just a few examples. It is hard to imagine the changes we will see in the next 100 years, but we do know that dedicated public health workers will lead the way.

The Public Health Improvement Plan is truly a team effort. This plan is the result of the efforts of hundreds of state and local health workers and their partners in communities around our state. Together we have created a vision that includes several key elements:

- Sustaining essential health services
- Mobilizing the newest and most effective technology
- Communicating important messages to the public
- Measuring performance
- Providing stable financing to get the job done

The Public Health Improvement Plan *is the result of the efforts of hundreds of state and local health workers and their partners in communities around our state.*

The PHIP focuses on how these activities fit together and support each other to improve the health of our families, friends, and neighbors. No state has shown a stronger or more consistent commitment to public health improvement. This work will also help ensure that the public health system can respond quickly to emergencies such as disease outbreaks and bioterrorism.

I take these recommendations seriously, and I look forward to implementing them in a continued public health partnership that is making a difference.

Thank you,

Mary C. Selecky
Secretary, Washington State Department of Health

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2000

"We envision a Washington where individuals, families, and communities are healthy. This Public Health Improvement Plan *shows what we are doing today—and what needs to be done in the future—to achieve that vision."*
—Lou Dooley, Chair, Washington State Association of Local Public Health Officials

Overview of PHIP 2000

What is "public health improvement" all about?

Washington State is recognized as a national leader for its coordinated efforts to improve its public health system. Since 1993, the state's network of public health agencies and their community partners have recast their work to advance public health's fundamental mission: promoting good health and protecting all people from illness and injury. Several states have followed Washington's direction for implementing policies and practices to serve these goals.

This document, Washington's fourth *Public Health Improvement Plan* (PHIP), reports on the progress of these efforts.

The Washington Legislature has provided policy direction for the state's public health system to focus on the "core functions" of public health and its "essential" services (see inside of the front cover). These directives stemmed from beliefs that:

- Our citizens *can* lead healthier lives.
- Our communities can become healthier places to live.
- It makes sense to prevent illness and keep our environment safe.
- We will meet these goals through long-term efforts, with public and private partners.
- Achieving better health depends on having a strong public health system.

These beliefs are essential to the overall mission of public health, which is to foster the conditions under which people can be healthy. Too often, people equate "health" with "illness" and "medical care." Public health reflects the balance of medical, genetic, environmental, and behavioral factors that are the true determinants of health status.

This approach is achieved through a unique public-private partnership. Public health operates both as government—local public health jurisdictions, the State Department of Health (DOH), the State Board of Health, and the University of Washington School of Public Health—and as a broad collaboration with community-based organizations and health care providers. The public health improvement process has helped to define government and community responsibilities more clearly, with public health agencies taking the lead in identifying health issues and helping people get the services they need.

Improving our health will not happen by accident or as a result of a single program. Many different factors affect our health, and many people are involved in delivering the broad range of services that protect health. Real health improvement will be achieved only through coordinated efforts on many fronts.

Using the *Public Health Improvement Plan* as a guide, the DOH and the state's 34 local public health jurisdictions, the State Board of Health, and the University of Washington have joined forces to strengthen the public health system throughout Washington. In every community, public health officials use funds provided by the Legislature to help local

governments implement creative approaches to improve community health. The local Boards of Health, citizen advisory groups, and other community partners use information about local health problems to set priorities for services that meet the specific needs of their communities.

In recent years, DOH has led several statewide health improvement initiatives that have benefited all of Washington's nearly six million residents. Examples are:

Local health assessments—Since 1994, every local public health jurisdiction has completed assessments of the health status of their communities. Through this work, local agencies have increased their skills in setting priorities and working with community leaders for health improvement and addressing conditions that need attention. The PHIP process has also directed flexible resources to communities to help them respond to local needs. (A list of local projects supported through the PHIP is shown in Appendix 2.)

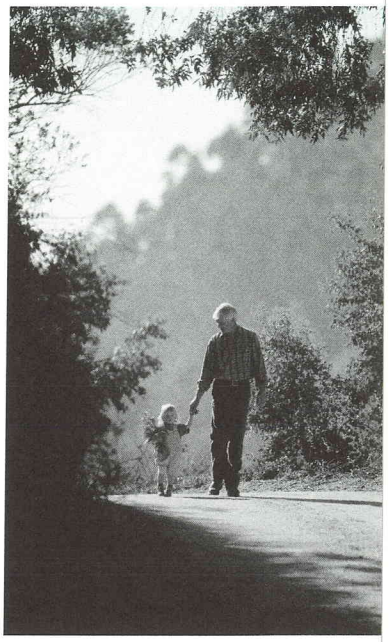
Tobacco prevention and control—Financed in large part by money from the national tobacco settlement, DOH staff have worked alongside hundreds of stakeholders to help smokers quit and discourage youth from starting to use tobacco products. The work is underway in communities, schools, and through a campaign on television and radio.

Diabetes management—The Washington State Diabetes collaborative, a partnership of providers, health plans, and public health officials, identified 12,000 people with diabetes in its first year of operation, helping to prevent blindness, amputation, and other conditions that occur when the disease goes untreated.

Additional examples of Washington's leadership are found in the pages that follow. They include an innovative process to develop standards for public health, leadership in public health workforce development, and development of emergency response plans for bioterrorism and other urgent health risks.

Despite Washington's impressive progress, the state's public health system must still address problems that result from years of underfunding, categorical restrictions, and incremental policy development. Like many states, Washington has never had a stable, system-wide method to finance public health activities. New funding pressures constantly emerge; currently, education and criminal justice programs consume increasing shares of local and state budgets, limiting the ability to fund public health programs.

In addition, Washington's public health system faces a deepening worker shortage, especially in the state's rural areas. Policy makers and administrators have not had common performance standards for guidance. Many of public health's most important functions—such as tracking and processing information about disease outbreaks—have been performed without the benefit of common databases and the most up-to-date and secure technologies. And despite the fact the public health system is constantly at work protecting the health of people in every community in the state, the public has little understanding or recognition of its role.



A shared vision for a healthy future

To address these problems, Washington's state and local public health officials have been working together to realize a vision of what Washington's public health system should be. They have pooled resources and set common goals to make that vision a reality.

Our strategic goals for Washington's public health system are to ensure:

- Key health indicators that identify and monitor communities' health and well-being
- Standards for public health agencies that ensure the provision of quality services that all citizens have a right to expect
- Information and technology that improve proficiency throughout the system
- A prepared workforce to address new public health challenges
- Stable and sufficient financing for public health
- Access to critical health services in communities throughout Washington that is achieved through public-private cooperation
- Improved public understanding of the role of public health, so all citizens become active partners in health improvement and fully use the system of health promotion and protection.

The seven elements of the PHIP work plan are tied together by their focus on better information, standards for performance, workforce preparation, and commitment to meeting the needs of every community. Together, they advance the system-wide, integrated approach to public health improvement that was launched with the first PHIP.

The seven elements of the PHIP work plan are tied together by their focus on better information, standards for performance, workforce preparation, and commitment to meeting the needs of every community.

The PHIP 2000 work plan: shared commitments

These seven goals provide the framework for the public health improvement work plan for the 1999-2001 Biennium. The Department of Health is working with local public health jurisdictions, the State Board of Health, the University of Washington School of Public Health and Community Medicine, expert consultants, and community members on a range of activities designed to achieve all of the needed system improvements.

More than 150 participants in eight committees have contributed to the work plan's progress and are developing recommendations for the future.

The *2000 Washington Public Health Improvement Plan* summarizes these activities to date. It explains how all of these efforts affect the efficiency and reliability of the state's public health system—and by extension, the health of everyone in the state. Recommended "Next Steps," shown on pages 11-12, explore important issues for the future, including anticipated system changes and costs. These are the actions that must be taken for Washington to achieve the public health improvement envisioned by our state leaders.

The PHIP Work Plan for 1999-2001

✔ Items completed by December 2000
☐ Items to be completed by June 2001

Work Plan Element	To Accomplish by June 30, 2001
Key health indicators	✔ Select framework and core indicators. ✔ Develop a report card. ☐ Implement indicator tracking system.
Standards for public health	✔ Conduct independent measurement. ✔ Revise standards. ✔ Publish "best practices." ☐ Recommend timeline and use.
Information and technology	✔ Revise reporting for notifiable conditions. ✔ Expand application of Public Health Issues Management System (PHIMS). ✔ Continue VISTA. ☐ Link surveillance to reporting statewide.
Workforce development	✔ Complete Leadership Workshop for local Boards of Health. ✔ Begin feasibility study for multi-state leadership program. ☐ Develop orientation materials and process. ☐ Assess training needs and develop curricula.
Financing public health	✔ Analyze distribution of state and local funds. ☐ Develop policy recommendations to increase flexibility, maintain clear accountability, and link funding to performance and outcomes.
Access to critical health services	✔ Develop menu of critical health services. ☐ Develop methods to measure access to critical health services.
Effective communication	✔ Evaluate research on effective communications. ☐ Provide products and training to use statewide.

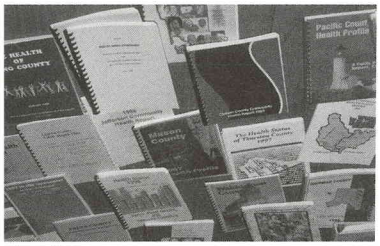
Next Steps

A Summary of Recommended Next Steps for Public Health Improvement in Washington

Specific steps for implementing the recommendations of the Public Health Improvement Plan committees are set forth in the "Next Steps" section following each chapter. Following is a summary of the key ideas.

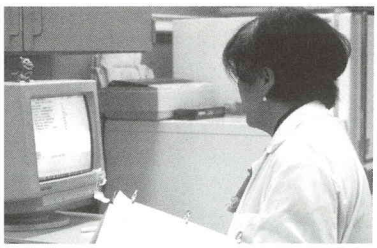
The 2002 Public Health Improvement Plan

The Public Health Improvement Plan Steering Committee recommends expanding alliances for public health improvement and engaging partners who can join efforts to improve the health of all people in Washington. Keep the PHIP partnership working as a joint understanding and ongoing commitment for public health system improvement. Establish a charter for the PHIP Steering Committee to oversee implementation of the 2002 Public Health Improvement Plan, and enact a new work plan for the 2001-2003 Biennium.



Assessing Our Health

The committee recommends that the proposed Washington Report Card for Health be circulated for additional comment on proposed indicators. Collect data for a preliminary report card and set a schedule for regularly publishing the Report Card. Evaluate data resources, and pay particular attention to the expanded use of behavioral risk factor information. As with the Report Card, update and publish *The Health of Washington State* on a regular schedule.



Measuring and Improving Washington's Public Health System

The committee recommends that the Proposed Standards for Public Health be adopted for use in Washington after incorporating minor modifications in format for specific measures. Put in place an ongoing process for using the standards in order to monitor public health system performance, including site reviews. Establish a baseline measure, then document the findings of future reviews of both state and local programs. Link the standards to contracting expectations and funding allocation formulas in a manner that will support improved efficiency and service quality. Routinely identify and circulate best practices in the field.

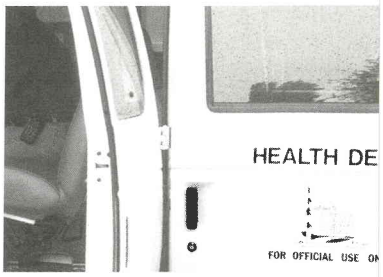
Putting New Information Technology to Work

The committee places top priority on development of common data standards and data policies throughout public health agencies. Adopt technology-based information exchange wherever possible, with addition of secure networks and web-based applications to improve customer service by local and state governments. Support a continued state-local effort to guide the transition to electronic formats and to seek cost efficiencies through coordinated planning.

Assuring a Ready, Capable Workforce

The committee recommends that data be collected to describe more accurately the public health workforce to allow for comparisons across jurisdictions. Increase representation of some racial and ethnic groups so that the workforce reflects the communities it serves. Base training and development opportunities on attainment of a set of core competencies for public health, and ensure that training methods make use of new technology wherever appropriate—to expand access and quality and to limit cost.

Developing Sufficient and Stable Financing



The committee recommends continued work on financing issues, including identifying a core set of services that can be used as a basis for need and cost estimates and linking financing strategies with the Proposed Standards for Public Health. Set forth clear expectations about which service costs are covered by state or local funds. Emphasize keeping funding flexible so that unique local and state needs are effectively met, and use incentives to support cost-effective public health services.

Identifying Gaps in Access to Critical Health Services

The State Board of Health recommends dissemination of the Menu of Critical Health Services to determine consensus and to consider possible approaches to mobilizing state and local efforts to address gaps in access to services. New research should identify what data exist to reveal access problems and to examine the feasibility of collecting information in order to identify specific goals for improving access to critical health services.

Improving the Public's Understanding of the Role of Public Health

The committee recommends increasing the effort to improve public understanding of the mission of public health. This should result in increased public participation in addressing and solving health problems. Help public health officials understand what the public needs to know to make good decisions about their health and the health of their communities; they should have effective materials and tools for public engagement.

Assessing our Health

How healthy are we? To help answer this question, we have developed a short "Report Card"—a list of measures to tell us, at a glance, what our overall health looks like.

A tremendous amount of information about health is available, and it is used for different purposes—for assessing health care needs, for setting clinical priorities, for developing preventive strategies, and for monitoring provider performance. Because of this breadth of uses, health information often appears confusing, complicated, and even contradictory to health policy makers and the public. The Washington Legislature sought to remedy this situation by directing the Department of Health to identify the "key health outcomes sought for the population and the capacity needed by the public health system ...in improving health outcomes."

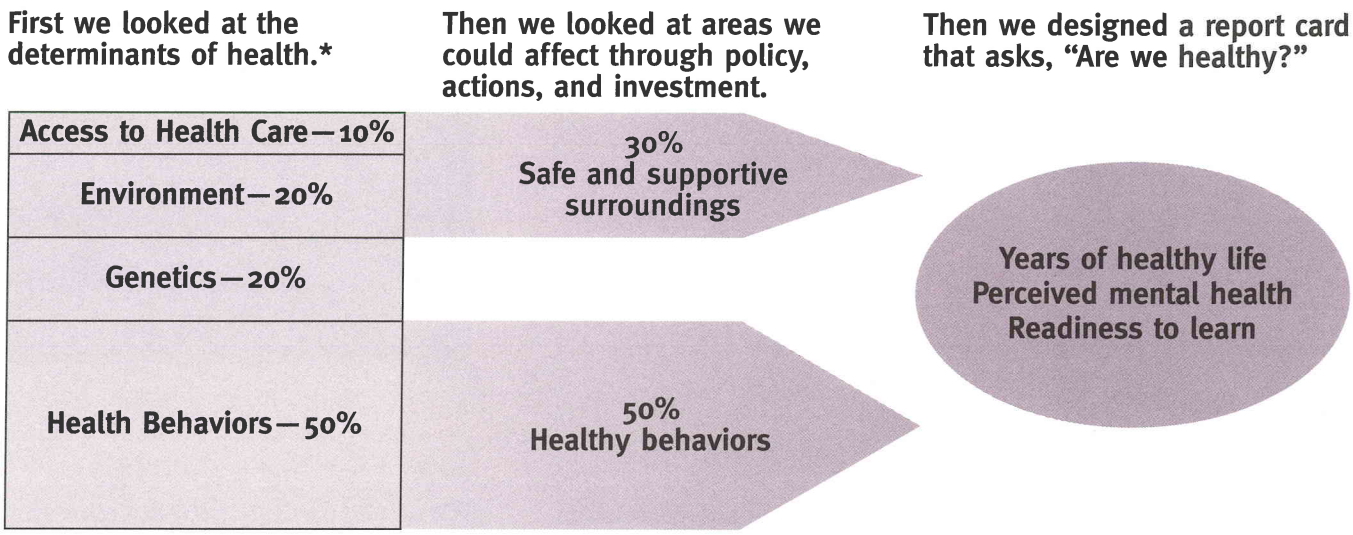
How healthy are we? We have a two-part strategy to answer this question. The first part is to develop a short "Report Card"—a list of measures to tell us, at a glance, what our overall health looks like. Health officials and public health partners have compiled a list for consideration, and it appears on page 15. This concise list of indicators is designed to help people think about health not in terms of diseases but in terms of the underlying causes of disease. These include social, community, and environmental factors as well as personal health behaviors.

The second part is to publish a more in-depth compilation of health indicators that can be used to examine specific health problems and to provide a concise summary of what scientific evidence supports as effective interventions. This strategy will be met with a new edition of *The Health of Washington State,* a periodic update on the health status of all who live in Washington, including interventions to improve health. The next edition will be published—with new data from the 2000 Census—in early 2002. A detailed list of health indicators to be included appears in Appendix 3.

Both the Report Card and *The Health of Washington State* will be used locally and at the state level by public health officials and many other partners to improve health status, draw people's attention to health issues, and ensure the accountability of all systems—health, social service, environmental, and educational—that contribute to people's health and well-being. Within communities, they will be used alongside the local health assessments completed by every health jurisdiction.

The Report Card focuses first and foremost on the physical and mental

How We Developed Washington's Health Report Card



*As adapted from the Journal of Public Health Management and Practice, March 1997

health of the population. The report card content is based on a model that shows what factors determine our health and translated this into health outcomes, as shown in the above graphic.

Scientific evidence connecting indicators with health status guided creation of the list. Public health officials, academic specialists, and community representatives participating in the process generally chose indicators of health over indicators of disease, underlying causes (nutrition, exercise) over "downstream" indicators (obesity), and indicators appropriate for the entire state population over those for subgroups.

The Report Card's indicators support three overall health outcomes. They are:

- **Years of healthy life**—This indicator, used in the federal Department of Health and Human Services report *Healthy People 2010*, combines life expectancy with quality of life, which is characterized by levels of functioning and absence of pain.
- **Perceived mental health**—This indicator provides a global indication of the sense of mental well-being.
- **Readiness to learn**—This reflects healthy brain development, nutrition, adequate medical care, and age-appropriate social development.

The Report Card identifies indicators that contribute to the three general health outcomes—in the context of our surroundings, our health care system, and the behaviors that affect our health.

"How safe and supportive are our surroundings?" addresses the safety of our air, food, water, the role of various community attributes, and the adequacy of health care. These factors together contribute 30% to health, according to the model.

The Report Card and The Health of Washington State *recognize the full scope of activities that contribute to health and in which our public health system is engaged.*

"How healthy are our behaviors?" examines tobacco use, nutrition, physical activity, and alcohol or drug abuse. These factors contribute 50% to health.

Although the Report Card differentiates surroundings from behaviors, they are closely linked. For example, hand washing is a behavioral component of food safety, and community norms (such as smoke-free work places) affect tobacco use.

Measures for the indicators are drawn from data such as those collected by the Behavioral Risk Factor Surveillance System (BRFSS)—a telephone interview that gathers information on health status, health-related behavior, and use of health services—and from notifiable conditions databases and other sources that are also shown in Appendix 3.

The Health of Washington State will, to the extent possible, present indicators that can be interpreted by counties as well as by sub-groups based on gender, age, race and ethnicity, and socioeconomic levels. Together, the Report Card and *The Health of Washington State* recognize the full scope of activities that contribute to health—from protecting the safety of food and water to assuring access to health care to preventing tobacco use—in which our public health system is engaged.

Report Card on Washington's Health—"How healthy are we?"

General Health Indicators:

- Years of healthy life
- Perceived mental health
- Readiness to learn

Specific Health Indicators:

"How safe and supportive are our surroundings?"

"How safe are our food, water, and air?

Illnesses commonly associated with unsafe food and water

Air quality

"How safe and supportive are our communities?"

Economic:

Percent below poverty threshold

Social connectedness:

Civic involvement, interpersonal trust, high school graduation rates

Injuries and death:

Unintentional—traffic, poisoning drowning, fires, falls

Family violence

Homicides and suicides

"How supportive is our health care system?"

Unmet need—adults, children

Vaccine-preventable diseases

"How healthy are our behaviors?"

"Do we use tobacco products?"

Percent non-smokers

"Do we get good nutrition?"

5 fruits and vegetables a day

"Are we physically active"

30 minutes—5 times a week

"Do we abuse alcohol and other drugs?

Binge drinking—5+ drinks

Next Steps

For Assessing Our Health

1. Circulate the proposed Washington Report Card for Health.
   - Seek comment on the indicators and ideas for improving them.
   - Finalize the report of the committee's work, and publish it separately.
   - Continue work to oversee the report and committee process.
2. Collect and publish data, using the Report Card indicators for which data are available.
3. Set a schedule for regularly reissuing and revisiting the Washington Report Card for Health.
4. Publish the detailed set of indicators, *The Health of Washington State.*
5. Begin development of necessary new data sources, and assess the viability of existing sources.
   - Give particular attention to development and support of BRFSS surveys and the need for more detailed information so that counties can effectively target resources to areas of greatest need.

Measuring and Improving Washington's Public Health System

The Proposed Standards for Public Health represent what should be in place throughout Washington's public health system.

As part of *Public Health Improvement Plan* development, the Washington Legislature requires minimum standards for public health agencies that are based on the core functions of public health. The guiding principle of this effort is to articulate, in clear language, what every citizen has a right to expect in the way of public health protection. These standards build accountability into Washington's public health system by setting performance levels for local and state agencies. Among other purposes, the standards may be used as a basis for contracting with local health jurisdictions and for budget and planning decisions at the state and local levels.

Setting standards and performance measures for public health agencies is especially challenging because each has its own local history, method of funding, and unique array of services. To meet this challenge with a practical set of standards, local and state public health officials first developed a framework that could be used across diverse communities. This framework and an example were published in the 1998 PHIP. In the following two years, more than 150 health officials throughout the state met to draft workable standards—four or five each—for five key aspects of public health:

- Protecting people from disease
- Understanding health issues
- Assuring a safe and healthy environment
- Promoting healthy living
- Helping people get the services they need

The Proposed Standards for Public Health represent what should be in place throughout Washington's public health system.

Local and state public health officials performed a self-assessment field test of the proposed standards. Next, they took the standards into the field, through on-site evaluation of the standards and their measures. This process involved scheduled site visits with all 34 local health jurisdictions and 20 DOH programs. The information gathered is being used to identify needed supports, resources, and training, and to provide a context for implementing a statewide performance measurement system.

The work has also produced a compilation of "best practices" that will jump-start quality improvement in both local jurisdictions and state programs.

Local-state collaboration has been a key principle in this effort. The standards were written to illustrate that there are both state and local responsibilities that must be met to keep the public health system performing effectively to protect the citizens of Washington State.

Both the on-site evaluation of the standards and the performance standards themselves follow a quality improvement process that emphasizes decision-making based on data, science, best practices, documentation of practice, evaluation of practice, and collaboration and partnerships.

The review process confirmed that the proposed standards:

- Set a reasonable expectation of performance, though all local and state public health agencies must stretch to meet them in most areas
- Are measurable
- Allow differences in performance among agencies to be identified and quantified

The table on the next page shows how local public health agencies and 20 state programs would be able to meet the proposed standards if they were in place today.

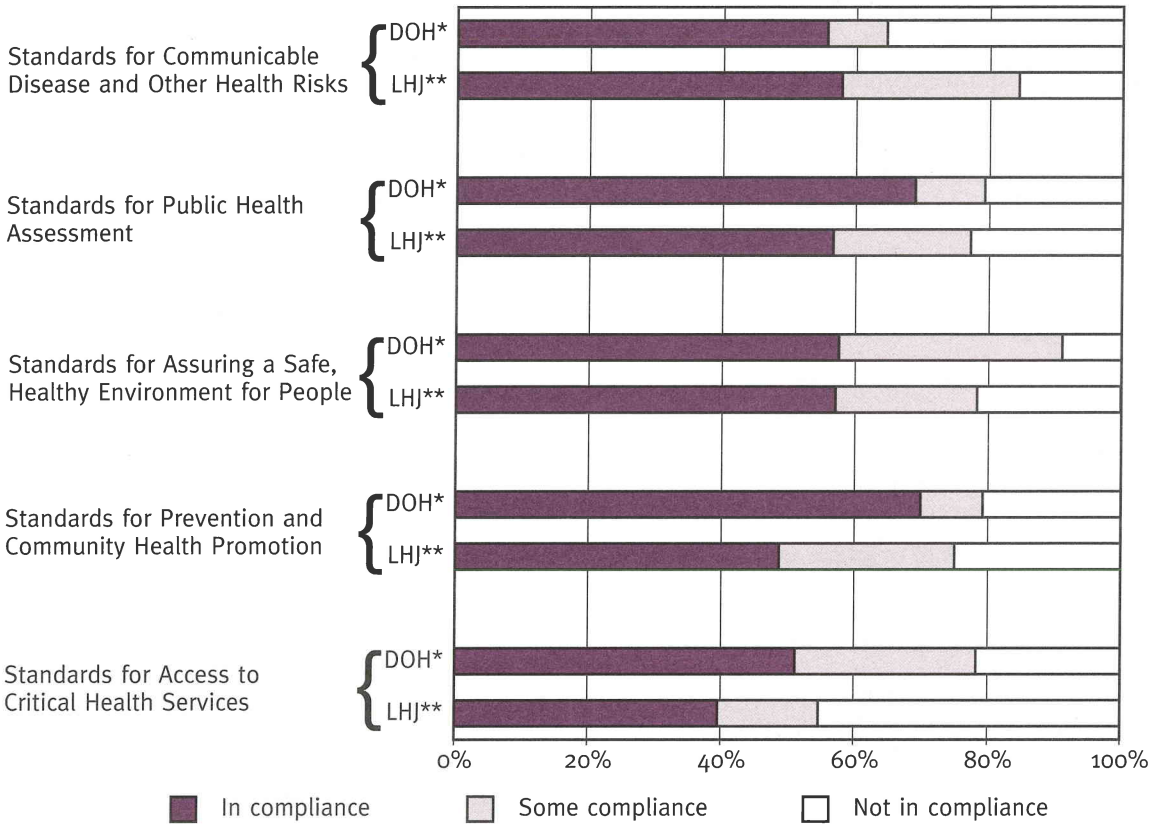
The review process was a test of the standards and measures, not an actual baseline measure. But the process provided excellent information about our public health system and will help us address many issues in the future. For example, on-site reviews revealed that:

- State and local public health agencies have substantial resource needs for more and flexible funding, staff with specific skills in areas such as assessment and quality improvement, more time for planning and resource development, more training opportunities, and access to standardized and integrated data bases and information systems.
- Many state and local public health agencies rely on institutional memory about staff roles—who to contact and how to complete tasks. Some communication processes at both the local and state levels are based on staff being "locally known." This situation causes problems in the event of staff changes and makes orientation of new staff more difficult.
- Funding drives the ability to conduct specific programs. Agencies with larger budgets and staff are more able to comply with the standards, particularly in the area of assessment. Small agencies may be particularly stressed in meeting the standards.
- The system works as well as it does because of the skills and dedication of public health staff and their commitment to health improvement.

The list of proposed standards appears in Appendix 4.

The review process confirmed that the proposed standards set a reasonable expectation of performance, though all local and state public health agencies must stretch to meet them in most areas.

Where We Are Today in Meeting Washington's Proposed Standards for Public Health



*Percent of selected DOH program sites
**Percent of LHJs

This chart shows the extent to which local public health agencies and a selected group of 20 DOH programs would be able to meet Washington's Proposed Standards for Public Health if the standards were in place today.

The chart shows findings from the field test of the standards—the first organized opportunity to apply the standards and observe current performance. While the terms "compliance," "not in compliance," and "some compliance" are used, it is important to remember that the evaluation process was focused on testing the standards themselves, not the sites. The site visits documented degrees of compliance as if the standards were an agreed-upon set of expectations that the public health agencies and programs had been working within for some time.

Next Steps

For Measuring and Improving Washington's Public Health System

1. Adopt the Proposed Standards for Public Health with minor modifications, based on field tests and independent measurement.

2. Implement an ongoing process for using the Proposed Standards for Public Health to measure public health performance:
   - Create a biennial site-review process and complete site visits within a fixed time.
   - Establish a baseline measurement before linking findings to financing decisions.
   - Publish system-wide and site-specific reports; use findings in budgeting and future PHIPs.

3. Link Proposed Standards for Public Health to funding allocations and contracts. Support achieving compliance with the standards by addressing:
   - Alternative ways to organize and deliver some services
   - Monitoring and reporting processes for state and local departments
   - Workforce development and training needs
   - Integration of quality improvement planning throughout the system.

4. Disseminate best practices materials, post and maintain them on a website, and routinely update these following future site reviews.

Putting New Information Technology to Work

The continuing investment in electronic data can bring impressive advances in terms of efficiency, data security, and quick access to information.

Our public health system is both a conduit and a storehouse for information about health: the frequency of disease, environmental risks, data generated by community assessments, and availability of clinicians and other service providers.

The exchange of this information occurs both between citizens and public health agencies and between the state Department of Health and local health jurisdictions. And although the government agencies are responsible for data storage and management, the data come from both public and private sources—people, labs, hospitals, clinics, and insurance companies.

As with all of business and government, public health agencies are increasingly affected by the move to electronic sharing and storing of data. Public health staff need timely data to do their jobs effectively—particularly when quick responses are needed. The continuing investment in electronic data can bring impressive advances in terms of efficiency, data security, and quick access to information. It also improves customer service by making certain types of information immediately accessible and speeding permitting processes.

State and local collaboration is essential in order to realize these benefits. Developing duplicative, separate systems would be wasteful and far too costly.

The work of the PHIP Public Health Information Technology Committee will improve the security, speed, and efficiency of information exchange. It carries forward the collaboration that linked all local jurisdictions through an electronic communications network. Agencies that once turned to the Department of Health to respond to vaccine shortages can now negotiate directly with local agencies that have vaccine to spare. Locating experts, analyzing health data, communicating changes in public policy, and negotiating state-local contracts have all been enhanced by this network.

In the next phase of this effort, public health staff are working to achieve significant improvements in use of information technology, particularly in managing disease reporting and information regarding environmental problems and threats. The next two pages present three examples of work that is underway.

Vital Statistics for Public Health (VISTA/PH)

Assessment—the work of collecting, analyzing, interpreting, and sharing information about health status—is one of the core functions of public health. Through assessment, public health officials and their partners identify their communities' important health issues in order to set priorities for interventions and public policy. To do this work, they need timely information that is specific to their communities as well as the computer skills to analyze it.

For this purpose, Public Health—Seattle and King County developed VISTA/PH, a software package for analyzing population-based health data. A key feature of VISTA/PH is that it provides a mechanism to examine particular geographic areas—groupings of counties, Census tracts, zip codes—in terms of several indicators of health and well being: births, deaths, infant mortality, abortions, hospitalizations, sexually transmitted diseases, and other reportable diseases. VISTA also provides ready access to information such as population characteristics (age, race), fertility and birth rates, and life expectancy. (Appendix 5 shows Washington State data available on VISTA.)

Local public health jurisdictions, their contractors, and universities have all used VISTA. Since 1996, the Department of Health has supported distribution of the system to local public health agencies across the state with purchases of hardware and software and training in data applications, basic epidemiology, and statistical analysis. Current efforts focus on adapting this software for secure network use as well as creating content for general web-based applications.

The Health Alert Network (HAN)

With its Health Alert Network (HAN), the Washington State Department of Health joins a national infrastructure that captures, analyzes, and processes disease surveillance information in a systematic way. Recent federal legislation and funding underscored the importance of being prepared for possible bioterrorist attacks and other large-scale health emergencies. HAN will provide a secure framework for local public health jurisdictions to share information with each other to locate the sources of disease outbreaks.

This work is essential because until recently, Washington's public health system faced numerous barriers to the rapid, accurate, and secure reporting of information. The state's public health agencies use different paper-based systems for conducting case investigations and completing reports. Lack of standard tools and definitions does not allow rapid response to emergencies or recognition of emerging issues.

HAN will provide the state's public health workers with the tools they need to react appropriately when faced with a major health threat. It will provide computer hardware, training, and security mechanisms needed to ensure the confidentiality of information and protect it from hackers and terrorists.

A key part of HAN is creation of a secure mechanism to transmit disease data throughout Washington's public health system through a "virtual private network" that will go online first in the state's metropolitan counties and statewide by August 2004.

The Health Alert Network will provide the state's public health workers with the tools they need to react appropriately when faced with a major health threat.

The Public Health Issues Management System (PHIMS)

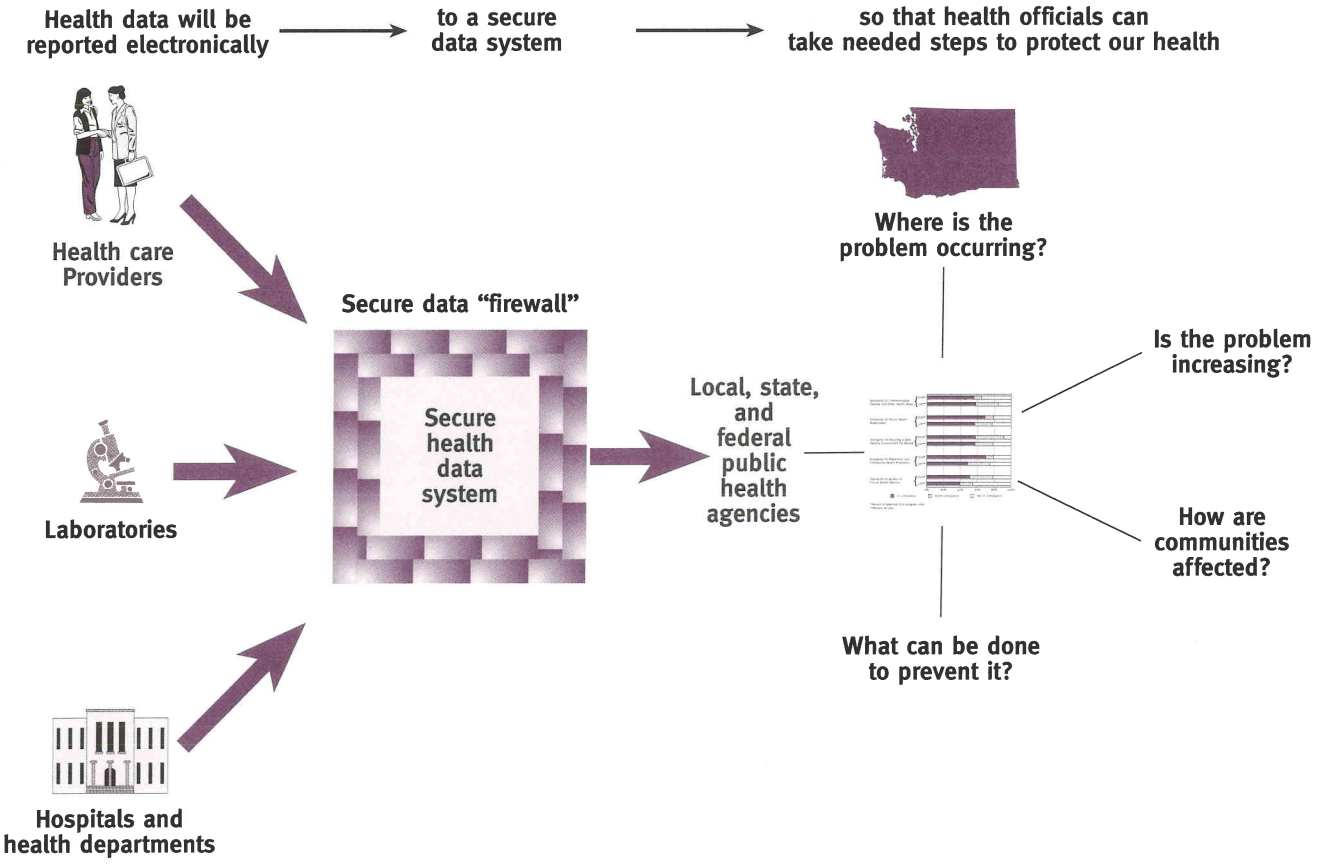
PHIMS is the first application to use HAN. Developed by the Thurston County Public Health and Social Services Department, PHIMS is a user-friendly system that public health staff can employ to investigate, manage, and report information about communicable diseases and other areas of concern. It also draws information from a wealth of different databases into analysis. (A list of "notifiable conditions" for Washington appears in Appendix 5.)

Once in PHIMS, staff can create new records by selecting templates from a list ranging from *animal bites* to *yersinia*.

Workers can quickly view and edit existing reports and charts, including clinical and lab data and detailed source and demographic information. PHIMS provides a secure mechanism to communicate all of these data electronically to DOH.

State public health officials are eager to expand PHIMS to all local public health jurisdictions that wish to use it through a secure, web-based system. PHIMS will be piloted in three local health jurisdictions by July 2001. The new system will be built to be consistent with all national and DOH information technology standards.

Standardized Electronic Health Data Reporting Will Be a Valuable Tool for Health Protection



Next Steps

For Putting New Information Technology to Work

1. Create common data standards and policies.
   - Develop and disseminate common data standards, compatible with national models, including federal standards and requirements.
   - Recommend policies on hardware, software, data sharing, confidentiality, and security.

2. Move to technology-based information exchange wherever possible, and make effective use of secure data transmission through special networks and expanded web-based technology where appropriate.

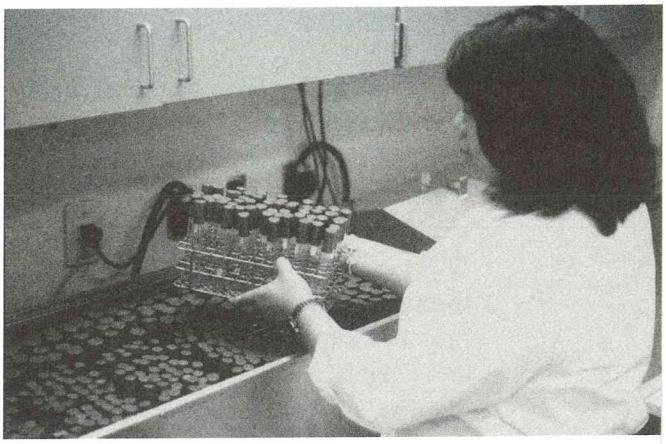
3. Use technology innovations and available resources to improve service to individuals and overall system efficiency in all local health jurisdictions and at DOH.

4. Seek continued support from federal entities for local and regional technology coordination.

5. Continue an oversight committee of state and local officials and partners to ensure that system-wide, information technology decisions and investments are made in a coordinated, timely manner.
   - Address emerging technologies such as Geographic Positioning Systems (GPS) and Geographic Information Systems (GIS).
   - Set priorities on issues that must receive system-wide attention.
   - Seek cost efficiencies in buying and supporting systems.

Assuring a Ready, Capable Workforce

People come from a variety of disciplines to work for public health agencies and bring skills—such as biology and nursing—to the field. But they often still need training in such specialized aspects of public health as core functions, how community systems work, and focusing activities on prevention.



More than 4,500 people work directly for Washington's governmental public health agencies, including 3,300 in local public health jurisdictions. Every day, they do the essential work of protecting the health of their communities.

People come from a variety of disciplines to work for public health agencies and bring skills—such as biology and nursing—to the field. But they often still need training in such specialized aspects of public health as core functions, how community systems work, and focusing activities on prevention.

In addition to the challenge of specialized training, the public health workforce must grapple with issues of turnover and workers leaving the field for retirement—both of which can cause vacancies in key positions within public health agencies and complicate planning.

To assure a well-prepared workforce, Washington's public health workers must have access to formal and informal training that includes the use of mentors, management training, access to technological resources for online information, videoconferencing—and the time to participate in learning activities. They need:

- A fundamental understanding of the mission of public health
- General knowledge of epidemiology, community assessment and mobilization, policy development, and health communications that enables the performance of the essential services of public health
- Technical knowledge for a defined program such as control of infectious disease, chronic disease prevention, and environmental health.

Through our workforce development efforts, Washington's public health system can provide opportunities that enhance workers' skills, knowledge, and aptitudes so they are able to perform services in accordance with the system's Proposed Standards. All who work in public health—managers, health officers, and public health staff, as well as new members of local Boards of Health and other community members—also need training to respond quickly and effectively to pandemics, to bioterrorism events, and to natural disasters such as fires and floods.

Workforce development for Washington's public health system has four priority areas that are described in the following pages.

Orientation

DOH and the Washington State Association of Local Public Health Officials (WSALPHO) has already produced a comprehensive orientation program for local health officers. Beginning in 1998, DOH surveyed local health officers throughout the state about their roles and responsibilities, which focused on seven areas: public health practice, infectious diseases, environmental health, epidemiology and assessment, management and leadership, relationships with key people and groups, and communications. Based on this information, state and local public health officials worked together to develop a largely self-guided orientation process that consists of:

- Meetings with key people at both state and local levels
- Mentoring with more experienced local health officers
- A menu of training options including references, written materials, and activities
- Online learning resources, including links to useful web sites and an interactive calendar of events

The scope of orientation activities will depend on staff roles and responsibilities and the individual's prior training and experience. Comparable packages are being developed for nursing directors, health jurisdiction administrators, and environmental health directors.

Learning to Be Prepared for Bioterrorism

Emergency preparedness is a key strategy of Washington's workforce development efforts. The University of Washington Northwest Center for Public Health Practice, in consultation with DOH, has developed a scenario for use in practical exercises that help public health officials prepare for response to bioterrorism, natural disasters, and epidemics.

Imagine for a moment...you are a health officer in a county where three important events have just collided:

Over the past few days, medical care providers have reported a high number of severe illness. Symptoms include fever, chills, headache, nausea and vomiting, abdominal pain, and possibly bloody stools. By evening, there are 75 cases and six people hospitalized. You suspect the illness was caused by food and have begun an investigation to find out what these patients have in common. Yesterday, the news media covered the outbreak.

This morning, an activist group called a local radio station and claimed to have contaminated restaurant food with botulism. But the symptoms don't match the claim, and the cases are not all linked to dining out. Public concern is high, and new cases are being reported hourly.

You just learned that a week ago, in a neighboring county, a research lab reported missing vials of the bacteria *Shigella sonnei*, which can cause severe gastrointestinal illness. A routine investigation was begun when the missing vials could not be located at the lab. Campus security contacted the county sheriff, who passed the information along to the local health department.

A swift, effective response to this scenario would require a well-prepared workforce and clear channels of communication among many organizations: public health agencies, law enforcement, hospitals, physicians, and news media. Before this is over, hundreds of workers will be involved. Workers must be ready to carry out individual responsibilities—and know how to work with all the others.

Orientation materials will address "public health basics" such as the core functions, background on communities and local government, initiating community contacts, and building job-related skills in areas such as budgeting, communications, outbreak detection, and program evaluation.

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Competency-based curriculum

From an analysis of training needs assessments of local public health officials, the University of Washington Northwest Center for Public Health Practice has concluded that the most pressing training needs concern improving communication skills, community involvement and mobilization, policy development and planning, improving teaching skills for health educators and others, and developing cultural skills to understand community values, concerns, needs, and attitudes. Based on these findings, which are summarized in Appendix 6, the Center will identify the training products that improve and increase staff performance.

The Center and DOH have collaborated on a training curriculum to prepare for public health emergencies such as a bioterrorism event. Health officers, public health staff, and community members (from schools, hospitals, fire departments, etc.) will participate in a practical exercise that provides training in the policy issues that arise from a scenario such as contamination of food products by a terrorist group. Participants learn to address these issues with planning, preparedness, and coordination.

DOH and the Northwest Center for Public Health Practice are also working together on curriculum to assist workers in developing community partnerships and strategies for managing change, as well as a regional training network that will serve six states across the Northwest.

The Northwest Public Health Leadership Institute

The Northwest Center for Public Health Practice is leading the collaborative planning process for developing a regional leadership program that will prepare public health leaders to cope with technological changes, demographic shifts, changing economies, and other trends that are shaping the health of communities. The Northwest Public Health Leadership Institute will help facilitate the growth and development of public health leaders throughout the public health system, both within and outside of government, by emphasizing "systems thinking," partnering and collaboration, and leading change. The Institute will generate new knowledge and opportunities to meet the learning needs of public health officials and members of local Boards of Health and other community leaders.

Training for local Boards of Health

Members of local Boards of Health make policy every day that affects Washington's public health system. They are primarily composed of elected county and city officials. For the past three years, WSALPHO (an affiliate of the Washington State Association of Counties) has brought these community representatives together from across the state for a two-day workshop in which they discuss state policy priorities as well as the public health issues they are likely to address in their communities. Local Board of Health members developed the content and design for the meetings.

Next Steps

For Assuring a Ready, Capable Workforce

1. Collect data that will accurately describe the public health workforce, allowing for comparisons of workforce capacity across jurisdictions and by program or type of work.

2. Increase the proportion of under-represented racial and ethnic groups in the public health workforce so it reflects the community it serves.

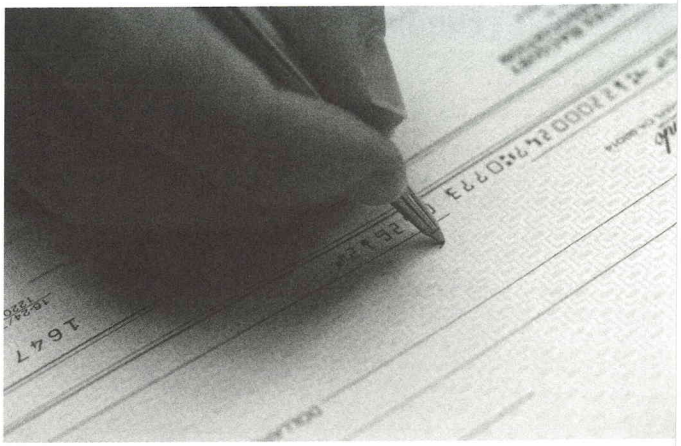
3. Use the Proposed Standards for Public Health, as well as nationally published material including the 10 essential services of public health, to select a set of public health competencies to use as guidelines for curriculum development.

4. Design a comprehensive workforce development resource management system, using new technology where appropriate, that makes training accessible, available, and easy to use. Identify incentives for participation in workforce development activities that are linked to the Proposed Standards for Public Health.

5. Establish a statewide advisory committee that includes a broad representation of public health partners to oversee implementation and evaluate the effectiveness of workforce development efforts over time.

Developing Sufficient and Stable Financing

The current financing system is a tangled knot of local, state, and federal funding sources, distribution formulas, and categorical restrictions.

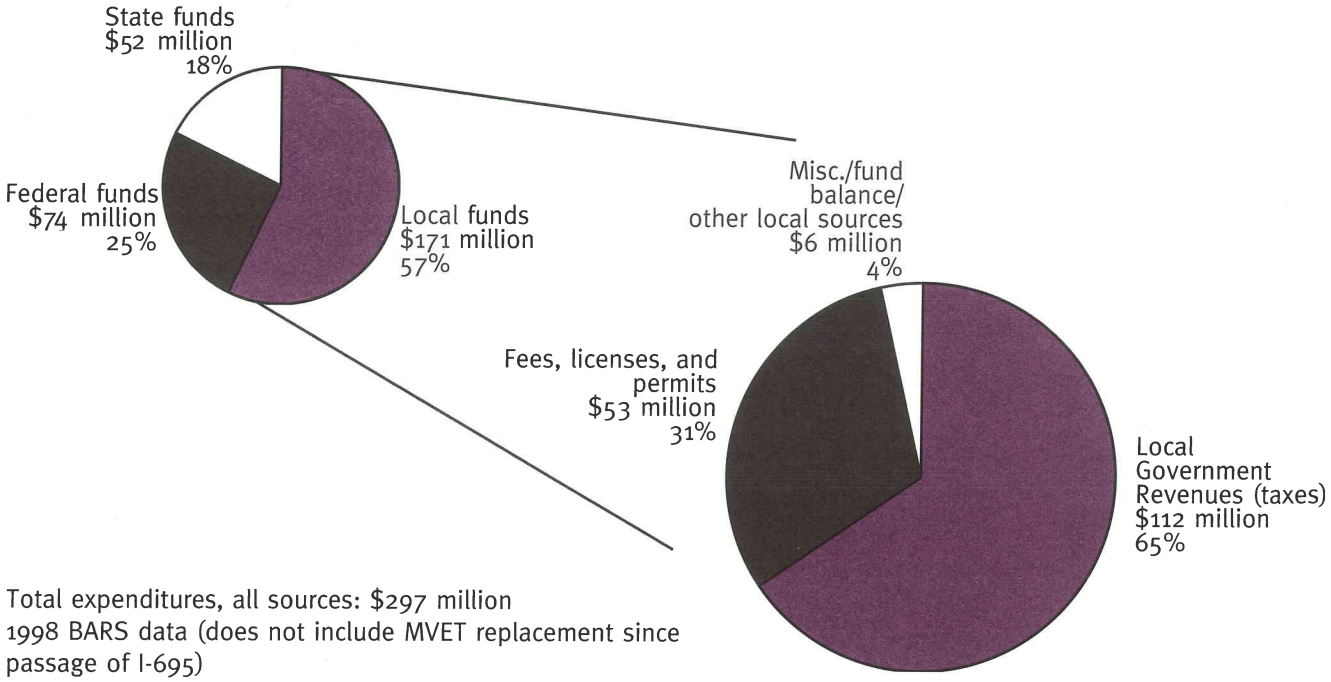


Washington's current funding system for public health has been shaped by years of incremental decisions, many tied to specific programs and resources. The current financing system is a tangled knot of local, state, and federal funding sources, distribution formulas, and categorical restrictions. This mix of funding delivers inconsistent support across local public health jurisdictions and causes some high-priority needs to go unmet. It falls far short of the financing principles listed in both the 1994 and 1996 PHIPs, which committed the state to developing a system of financing public health that is stable and sufficient.

The PHIP Financing Committee set out to analyze the distribution of funding for Washington's public health system and to develop policy recommendations to increase funding flexibility, maintain accountability, and to link funding to system performance. The committee identified three overall problems facing the state's public health system:

- Financing has evolved without established principles, and there are wide variations in the level of public health investment. An analysis of 1998 spending revealed significant disparities across Washington counties both in how communities measure what they pay for in public health services and, more important, the level of local investment in public health. For example, according to county reports, average local-fund investment in public health is $22.08 per capita. But the range in local funds across counties is great, from $7.65 to $41.45. The disparity of investment from one area to the next suggests that all Washington's citizens do not have the same level of public health protection.
- Public health funding is allocated according to complex and inconsistent methods. Local health jurisdictions often lack trust in distribution formulas that do not change along with changes in population and public health priorities. Categorical funding constrains responsiveness to community priorities and undermines cost-effective use of funds.
- The financing system needs a stronger link between services and funding to support good decision making and demonstrate public health's "return on investment."

Funding for Washington's 34 Local Public Health Jurisdictions



Total expenditures, all sources: $297 million
1998 BARS data (does not include MVET replacement since passage of I-695)

After defining these problems, the Public Health Financing Committee conducted an analysis of the current revenue and expenditure streams for Washington's public health system, current financing formulas, and other state financing models. This involved an in-depth study of both the Department of Health budget and local expenditures. Local funding sources are shown in the chart above. State and federal funds expended by local health jurisdictions come from DOH and other state agencies. Department of Health revenues and expenditures are shown in Appendix 7.

The committee then collected insights from local public health officials to develop a guiding philosophy for financing public health. This philosophy rests on the following underlying principles:

- Public health funding is a shared responsibility of federal, state, and local government.
- The state's role is to develop and administer the public health system and the state and federal revenues that support it.
- The role of local health jurisdictions is to provide or assure provision of a basic set of public health services in their communities, including locally determined strategies to meet public health performance standards.
- Federal, state, and local funds can be used most effectively when restrictions are few, while maintaining accountability for public health outcomes.
- Education about the essential role of public health is needed at all levels of federal, state, and local government and with the public.

Creating a stable and sufficient system will require system-wide solutions and continuing state and local collaboration.

By adopting these principles, the committee embarked on a process for recommending changes in the state's public health financing system to achieve the goals expressed in the 1994 and 1996 PHIPs. The framework for developing these recommendations is shown in the chart below.

Policy makers need this guidance more than ever. Federal, state, and local governments share responsibility for financing the state's public health system. During the past decade, however, county governments—in Washington and across the nation—have become increasingly strapped for resources as they try to meet rising costs, particularly those associated with criminal justice needs. State programs are subject to the stresses caused by state spending lids and categorical funding sources. Creating a stable and sufficient system will require system-wide solutions and continuing state and local collaboration.

Building a Vision for Financing Public Health

Underlying Principles
What is the philosophy behind how we pay for the public health system?

Revenues and Their Allocation
What sources support the overall system?
How are revenues allocated among state and local health jurisdictions and community providers?

Expenditures and Their Allocation
What are roles and responsibilities of state and local health jurisdictions and community providers?
How are priorities set between programs and uses to provide service?

Health Improvement Measures
What are we getting for our investment?

Next Steps

For Developing Stable and Sufficient Financing

1. In concert with the Proposed Standards for Public Health, identify a basic set of state and local public health services that should be available to every citizen, estimate the cost to deliver those services, and establish how funding will follow the provision of "basic" services.

2. Develop financial incentives for efficient local organization and alternatives to meet the standards, including technical assistance that helps local health jurisdictions maximize revenue capacity.

3. Establish funding responsibilities—"who pays" for a service—among state and local governments.

4. Work to make revenue sources more flexible so resources effectively meet local and state needs and are allocated within the public health system using well-communicated, regularly updated criteria.

5. Continue to communicate to funding agencies, partners, and the public:
   - Financing principles that convey how resources should be used in the system
   - The shared nature of local and state financing responsibilities
   - The need for enough stable funding to meet public health standards

Identifying Gaps in Access to Critical Health Services

Local and state public health jurisdictions monitor access to critical health services and work with the entire health care system—including health plans and public, private, and community-based providers—to pinpoint service gaps and seek solutions.

When people do not have access to the individual health services they need, their health suffers. When many people in a community have this problem, the health of the community suffers.

In our state, one policy approach to helping people get the health services they need has been to provide subsidized payments for health insurance for those who cannot otherwise afford it. But when people have difficulty accessing individual clinical care, the community may expect public health departments to take on the burden of filling an access "gap"—providing a specific service such as immunizations or health screening. This has left an inaccurate impression that "public health" exists to provide medical care for the poor.

In fact, health departments, as part of local government, are set up for community-wide health protection; providing clinical services is a very small part of what they do. Only rarely do public health agencies provide health services directly, and the range of services is typically limited. Today, health departments most often work to make sure that services are available from other providers.

Public health plays a broader role in assuring access. Local and state public health jurisdictions monitor access to critical health services and work with the entire health care system—including health plans and public, private, and community-based providers—to pinpoint service gaps and seek solutions. More local health jurisdictions are finding this assurance role to be important because when this responsibility is not met, the health of the community may be affected and there may be increased pressure for local public health to fill the gap. This leads to pressure for greater public expenditure and piecemeal medical care.

The public health system's concern about access to critical health services stems from its mission to prevent illness and promote health. Its priorities for access may be different from those of employer sponsors of health insurance benefit programs or individuals who purchase major medical insurance coverage.

Given rapid changes in the health insurance market and health care delivery system during the past decade, attention to access issues by public health agencies is timely and essential. In several of

Washington's rural counties, individual health insurance coverage is severely limited. Hospitals, clinics, and health departments report difficulty in recruiting providers and remaining financially viable. Culturally appropriate providers are in extremely short supply to treat African Americans, Hispanics, Asians, Native Americans, and other populations at highest risk for many diseases. These issues are being evaluated at the state level by the State Board of Health, which has taken the lead on access to critical health services.

In addition, the Proposed Standards for Public Health contain a section addressing Access to Critical Health Services, which includes measures such as "information...about the availability of a core set of critical health services that are necessary to protect the public health." The State Board of Health's work on defining critical health services is an important first step in determining which services are truly essential in each community.

The definition of critical health services was accomplished using national research regarding impact on individual health—and by extension, community health—without reference to funding and payment considerations. These are services that should be available through local health systems, which consist of both private and public or community-based providers. (The conceptual framework for identifying these services is shown in Appendix 8.)

Because of local differences in population, geography, and provider availability, a standard list of critical health services does not work well in every local health jurisdiction. For this reason, the Washington State Board of Health has proposed a broader "menu" of services for use by each local health jurisdiction as appropriate. The adopted menu of critical health services is shown on the next page.

These are the services that our public health system may work to ensure are provided in every community or county across the state. At the beginning of this work, the Board of Health also planned to measure access to the above services by examining whether the service exists at the community level, how many people receive it, and whether the available services meet local need. The Board of Health's initial review of public and private sector data sources revealed that, because of problems obtaining complete, accurate, and service-specific data, reliable measurement over time is not yet possible. The data that exist are used primarily for claims and program management, not for tracking population-based access to care.

The Board of Health will share the menu of critical health services with communities and across government agencies and work with them to consider possible approaches to mobilizing state and local efforts to fill the gaps.

At the statewide level, additional work is needed to develop data that support ongoing assessment of access to critical health services. To be useful, such measurement must track over time, account for both public and private health care providers, and reveal differences across local jurisdictions. This collaborative effort will support the continuing work of closing the gap between the commitment to ensure access to care and the services that are available in every community.

The Board of Health will share the menu of critical health services with communities and across government agencies and work with them to consider possible approaches to mobilizing state and local efforts to fill the gaps.

Menu of Critical Health Services

This menu identifies health care services and health conditions or risks for which appropriate services—screening, education and counseling, and interventions—are needed.

General access to health services

- Ongoing primary care
- Emergency medical services and care
- Consultative specialty care
- Home care services
- Long-term care

Health risk behaviors

- Tobacco use
- Dietary behaviors
- Physical activity and fitness
- Injury and violence prevention (bike safety, motor vehicle safety, firearm safety, poison prevention, abuse prevention)
- Responsible sexual behavior

Communicable and infectious diseases

- Immunizations for vaccine preventable diseases
- Sexually transmitted diseases
- HIV/AIDS
- Tuberculosis
- Other communicable diseases

Pregnancy and maternal, infant, and child health and development

- Family planning
- Prenatal care
- Women, Infants and Children (WIC) services
- Newborn and early childhood services
- Well child care

Behavioral health and mental health services

- Substance abuse prevention and treatment
- Depression
- Suicide/crisis intervention
- Other serious mental illness

Cancer services

- Cancer-specific screening (i.e., breast, cervical, colorectal) and surveillance
- Specific cancer treatment

Chronic conditions and disease management

- Diabetes
- Asthma
- Hypertension
- Cardiovascular disease
- Respiratory diseases (other than asthma)
- Arthritis, osteoporosis, chronic back conditions
- Renal disease

Oral health

- Dental care services
- Water fluoridation

Next Steps

For Identifying Gaps in Access to Critical Health Services

1. Disseminate the recommended menu of critical health services to determine if consensus exists among health providers, community members, public health and other agencies as to which services should be targets for access improvements.

2. Use the critical services menu to identify priorities for special efforts to improve access.

3. At the state level, determine the feasibility of collecting information that describes the availability of critical services.
   - For which are there reasonable sources of data?
   - For which would information systems need to be developed?
   - Can coordinated efforts across state or private agencies yield information?

4. Explore the extent to which existing information systems and monitoring practices might be used or modified to help pinpoint exactly what services are needed—and where.

Improving the Public's Understanding of the Role of Public Health

Much can be accomplished when people and organizations band together to solve health problems. Such efforts have persuaded the public to wear seatbelts, stop drinking and driving, and ensure smoke-free environments.

Clean water. Safe food. Immunizations. Response to disease outbreaks. Explanations of why people are experiencing illness and what can be done to prevent it. People value these functions, as local and national surveys plainly show. But they do not know that public health is responsible for them.

A January 1997 Harris Poll showed that more than 80% of those surveyed ranked disease prevention, immunization, and protection from unsafe water and air to be "very important." But of participants in a 1999 national poll who were asked what they thought "public health" meant, only 27% identified "programs that maintain healthy living conditions," while 23% mentioned health services for poor people.

Focus groups conducted by the U.S. Centers for Disease Control and Prevention (CDC) revealed that members of the public generally expressed a high level of trust in public health work, even when they distrusted government in general.

The public generally understands what a fire department, police department, or school district does. And they understand that these services have important effects on their quality of life.

The public recognizes public health services as equally important, but it does not associate these services with their local or state public health agencies.

All residents of a community benefit from public health services, regardless of whether they ever walk through the door of a public health agency. But when the public doesn't understand this, people are less likely to work with public health agencies or programs to solve local health problems. This lack of awareness thus impedes the public health system's ability to protect and improve health.

When public and private organizations do not understand the depth of services provided by public health agencies, valuable partnership opportunities are missed. And policy makers miss opportunities for problem solving and health improvement when they do not turn to public health agencies for advice and technical consultation.

DOH, the State Board of Health, and WSALPHO are working together to increase the public's understanding of public health services. With that understanding, community leaders will set clear goals for better health and build alliances

Some of the Many Ways that Public Health Is Influencing the Health of our Communities

People need to know that they have the public health system to thank when they—

- Are confident that the tap water in their homes is safe to drink.
- Eat in a restaurant without fear of contracting a foodborne illness.
- Know that the child waiting in line near them at the supermarket is immunized against measles and polio.
- Relax in a theater or hotel lobby without breathing tobacco smoke.
- Drive with the knowledge that other drivers are wearing seatbelts, and bicyclists are wearing helmets.
- Send their children to school with other children who are growing up without abuse and neglect because of programs that strengthen families.

to achieve them. In addition to increased partnerships, individual community members will have a better understanding of the health of their communities and the role they can play as individuals and families in identifying and solving collective health problems.

Much can be accomplished when people and organizations band together to solve health problems. Such efforts have persuaded the public to wear seatbelts, stop drinking and driving, and ensure smoke-free environments at home and in public.

The PHIP partnership will develop strategies to inform and involve the public, resulting in a coordinated approach with all of the state's public health agencies to foster greater understanding of public health, how it works, and why it is a critical part of every community's basic services.

This effort will help our health departments develop a clear voice in their communities, and it will help all our potential partners make the connection between what they value in terms of health and how the public health system protects them.

Next Steps

For Improving the Public's Understanding of the Role of Public Health

1. Increase public understanding of the mission of public health: to protect and improve the health of all people in Washington State.
2. Improve public understanding of the breadth and depth of public health services, and increase public participation in addressing and solving health problems.
3. Obtain a better understanding of what the public needs to know in order to make good decisions about its health and the health of its community.

2000

Appendices

Appendix 1: Work Groups

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Appendix 2: Anticipated Local Investments for Flexible Funding in 2001

Local Health Jurisdiction	Project
Adams County Health District	Administrative Capacity Improvement
Asotin County Health District	Community Health Assessment Community Surveillance Management Systems
Benton-Franklin Health District	Child Care Health Environmental Health Education Activity Expansion Environmental Health Education-Outreach Marketing Public Health Functions Physical Activity, Fitness & Public Health Improvement
Bremerton-Kitsap County Health District	Community Health Assessment Injury Prevention Project Parenting Skills Program Preventing Initiation of Tobacco Use Among Youth
Chelan-Douglas Health District	Child Care Food Safety Internet-Based Community Information & Referral On-Site Sewage Replacement & Summary Abatement Rural Access
Clallam County Department of Health and Human Services	Communicating Public Health Messages Environmental Health Traveling Educational Unit Staff Development and Training Staffing to Support Programs and Services
Columbia County Health District	Administrative Leadership & Infrastructure
Cowlitz County Health Department	Bloodborne Disease Prevention Community Health Assessment Update Community Health Partner Collaboration Injury Prevention Reduction of Blood Lead Levels in Children
Garfield County Health District	Administrative Leadership & Infrastructure Development
Grant County Health District	Children with Special Health Care Needs Community Health Assessment Fit for Life II

Local Health Jurisdiction	Project
Grays Harbor County Public Health and Social Services Department	Community Health Assessment Revision Community Health Education Capacity Building Safe Drinking Water Program
Island County Health Department	Community Health Assessment/Process
Jefferson County Health and Human Services	Health Care Access Partnership
Kittitas County Health Department	Child Care Health Promotion Community Assessment
Klickitat County Health Department	Coordinating Food Safety Activities Fiscal Management Practices On-Site Sewage Disposal Code Revision Preventing Violence
Lewis County Public Health Department	Assurance of Food Safety at Public Events Assuring a Healthy Start Infant-Toddler Growth Clinic Safe Drinking Water from Small Public Water Systems Strong Assessment/Surveillance Capacity
Lincoln County Health Department	Food Safety Policy Development Pool Safety Training and Education
Mason County Department of Health Services	Nurse Home Visitation Project Ergonomics Upgrade for Health Department Staff Program Support for "Mason Matters"
Northeast Tri-County Health District	Assessment/Surveillance Capacity Cardiovascular Risk Reduction Food Protection Program Public Water System Sources Water Recreation
Okanogan County Health District	Assessment
Pacific County Health Department	Assessment Water Quality Evaluation
Public Health—Seattle and King County	Access to Primary Health Care Chronic Disease Prevention and Healthy Aging Community Assessment Community-Based Public Health Practice Community-Driven Public Health Interventions Diversity Initiatives Drinking Water Program

Local Health Jurisdiction	Project
Public Health—Seattle and King County (continued)	Environmental Health Education Injury and Violence Prevention King County Health Action Plan Maximizing Revenue Potential Public Health Education and Communications Tobacco Prevention Program
San Juan County Department of Health and Community Services	Designated Registrar Health Assessment Newborn Outreach/Home Visiting
Skagit County Department of Health	Community Assessment Pregnancy Prevention/Family Planning Safe and Healthy Child Care Welcome Baby!
Snohomish Health District	Partners in Child Care Protection of Potable Water Supplies Communicable Disease Programs Tobacco-Related Morbidity
Southwest Washington Health District	Community Assessment Community Health Promotion Initiatives
Spokane Regional Health District	Child Passenger Safety and Occupant Protection Community Assessment on Unintended Pregnancy CSHCN Early Intervention Linkages Data System Integration-Violence Toward Children East Side (Regional) Oral Health Coalition Epidemiology Communicable Disease Newsletter EPSDT and the ABCD Program First Steps Staff Diversification Healthy Seniors-Injury Prevention Healthy Seniors-Clinical Services Healthy Seniors-Nutrition Screening and Education Injury Prevention Grant Writer New Food Safety Measuring Tools for Surveillance Providing Food Safety Tools During Holidays Public Health Communicable Disease Liaison Report of the Community Health Survey 2000 School Guidelines Training The Prevalence and Consequences of Poverty Violence Prevention
Tacoma-Pierce County Health Department	Evaluation of Initiatives Family Support Services and Evaluation Health of Pierce County Assessment and Report Long-Term Monitoring Population-Based Alcohol Misuse Prevention

Local Health Jurisdiction	Project
Thurston County Public Health and Social Services Department	Quality Improvement of Surface and Ground Water Safe Drinking Water Supplies Safe Food from Commercial Food Service Establishments Safe, Healthy Child Care Environments Control of Communicable Diseases
Wahkiakum County Health and Human Services Department	Injury Prevention Coalition
Walla Walla County-City Health Department	Environmental Health & Water Lab Program Support Handwashing Promotion Program Health Education Program/Assessment Coordinator
Whatcom County Health & Human Services Department	Bright Futures Community Health Assessment Community Health Partnership Data Application Environmental Health Software Enhancement Fiscal Management Inter-System Collaborative Pilot Project Childhood Immunization Survey
Whitman County Health Department	Pregnancy by Choice Public Health Improvement Plan Sexually Transmitted Infection Prevention Tuberculosis Case Identification
Yakima Health District	CD Surveillance, Investigation, and Control

Appendix 3: Measures for Health Indicators

The following measures were identified for the Washington Report Card for Health.

How healthy are we?

Years of healthy life—Measured by combining an abridged life table and age-specific estimates of health-related quality of life. The abridged life table assumes that a hypothetical cohort is subject throughout its lifetime to age-specific death rates observed for the actual population for that year.

Health-related quality of life—Includes self-perceived health as measured by the survey question, "Would you say that in general your health is: excellent, very good, good, fair or poor?" and activity limitation (not limited, not limited in major activity, limited in major activity, unable to perform major activity, unable to independently perform instrumental activities of daily living, unable to independently perform self-care activities of daily living). Perceived health and activity limitation data are available through the Behavioral Risk Factor Surveillance System (BRFSS).

Perceived mental health—Measured with the survey question, "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" This question is included in the BRFSS.

Readiness to learn—Currently no direct measure for this indicator. The most common proxy measure is enrollment in preschool education programs. This proxy measure suffers from several shortcomings, most notably that there are no adequate standards for judging preschool programs. There is a need to develop a reliable, direct measure of readiness to learn.

How safe and supportive are our surroundings?

Safe food and water—The first measure is total number of cases for illnesses commonly associated with unsafe food and water. The illnesses included in the measure are

- Acute viral gastroenteritis
- Campylobacteriosis
- E. coli 0157:H7 infection or hemolytic uremic syndrome
- Giardiasis
- Hepatitis A
- Listeriosis
- Salmonellosis
- Shigellosis
- Vibriosis (non-cholera)
- Yersiniosis

The second measure of food and water safety is the percent of the population for whom drinking water systems are out of compliance with standards.

Air quality—Outdoor air standards cover the following components: particulate matter, carbon monoxide, nitrogen oxides, sulfur oxides, ozone, and lead. The measure is the percentage of population for whom ambient air quality standards are not met.

How safe and supportive are our communities?

Economic well-being—Measured by the percent of Washington State households with incomes less than double the U.S. poverty threshold.

Social connectedness—Measured by the BRFSS question, "Now we would like to know something about the groups or organizations to which individuals belong. Here is a list of various organizations. Could you tell me whether or not you are a member of each type?"

Interpersonal trust—Measured by the survey questions, "In general, do you believe that most people try to be fair? Or try to be helpful? Or can be trusted?" These questions are not currently asked of a Washington State population sample and would need to be added to an existing survey. In addition to civic involvement and interpersonal trust, high school graduation rate is included as a measure of social connectedness.

Injuries and death—Unintentional injuries are measured as the number of injuries and number of deaths from the major causes, including traffic related, falls, poisoning, drowning, and fires and burns. Intentional injuries or violence is measured separately for family violence, child abuse and neglect, and for homicides and suicides. Family violence is measured as the number of reported crimes involving domestic relationships. Child abuse and neglect is measured as the number of suspected cases accepted by Washington State Division of Child Protective Services for investigation. Homicides and suicides are measured as victims or deaths per 1,000 population.

How healthy are our behaviors?

Tobacco use—Measured in the BRFSS by the question, "Do you now smoke cigarettes every day, some days, or not at all?"

Nutrition—Measured by a series of questions in the BRFSS asking about the frequency in which the individual eats or drinks fruit juice, fruit, green salad, potatoes, carrots, or other vegetables.

Physical activity—The BRFSS survey asks, "How many days per week do you do these [at work or in leisure] moderate activities for at least 10 minutes at a time?" and, "On days when you do moderate activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities?"

Alcohol abuse—The following question is used to identify binge drinking, "Considering all types of alcoholic beverages, how many times during the past 30 days did you have five or more drinks on an occasion?"

How safe and supportive is our health care system?

Unmet health care need—Measured with a series of survey questions in the BRFSS. "In the last 12 months, were you or any adult in your household unable to obtain any type of health care you thought you needed? This is followed by the query, "In the last 12 months, did you or any adult in your household experience difficulty or delay in obtaining any type of health care you thought you needed?"

Vaccine-preventable diseases—Measured by the number of cases of the following illnesses: pertussis, Haemophilus influenza, measles, mumps, rubella, tetanus, and Hepatitis A and B (acute).

The Health of Washington State Topics

The following topics will be described in detail in *The Health of Washington State,* to be published by the DOH in 2001. Measures to be included are:

Washington: State and People
Geography, climate
Boundaries, jurisdictions
Population, demographics, socioeconomics, rural v. urban

General Health Status
Total deaths, leading causes, life expectancy
Self-reported health status
Hospitalization

Major Risk and Protective Factors
Tobacco use, exposure
Alcohol and drug disorders
Physical inactivity
Sexual behavior
Nutrition
Social determinants of health

Infectious Disease
Immunizations
Tuberculosis
Hepatitis A, B
Meningococcal disease
HIV/AIDS
Syphilis, Gonorrhea, Chlamydia
Antibiotic resistant infections
Emerging infectious diseases
Dental caries

Chronic Disease
Coronary heart disease
Stroke
High blood pressure
Lung cancer
Colorectal cancer
Female breast cancer
Cervical cancer
Melanoma
Asthma
Diabetes
Arthritis

Violence and Injury
Motor vehicle injuries
Suicide
Falls among people 65 and older
Head and spinal cord injury
Drowning and near-drowning injuries
Homicide
Child abuse and neglect
Domestic violence
Youth violence

Maternal and Child Health
Prenatal care
Adolescent pregnancy
Low birthweight
Infant mortality
Children with special health care needs
Unintended pregnancy and birth

Environmental Health
Drinking water quality
Food safety
Shellfish protection
Pesticide poisonings
Air quality (indoor and outdoor)
Water recreation
Emerging topics
Childhood lead poisoning

Health Systems
Health insurance coverage
Access to essential health services
Availability of health care
Emergency Medical Services response times
Health professional quality assurance
Health facility quality assurance
Laboratory proficiency testing
Capacity for emergency response

Occupational Health
Occupational lead poisoning
Fatal occupational injuries
Work-related musculoskeletal disorders
Occupational asthma

Appendix 4: Proposed Standards for Public Health

In addition to the standards shown below, specific measures have been developed for each standard both for state and local health jurisdictions. Contact DOH for additional information.

Standards for Communicable Disease and Other Health Risks

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

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

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

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

Standard 5
Communicable disease and responses to other health risks are routinely evaluated for opportunities for improving public health system response.

Standards for Public Health Assessment

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

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

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

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

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

Standards for Assuring a Safe, Healthy Environment for People

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

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

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

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

Standards for Prevention and Community Health Promotion

Standard 1
Policies are adopted that support prevention priorities and that reflect consideration of scientifically based public health literature.

Standard 2
Active involvement of community members is sought in addressing prevention priorities.

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

> Prevention services may be focused on reaching individuals, families, and communities. Examples of prevention services include chronic disease prevention, home visiting by public health nurses, immunization programs, and efforts to reduce unintentional injuries and violence, including sexual assault.

Standard 4
Prevention, early intervention, and outreach services are provided either directly or by contract.

> Examples of health promotion activities include educational efforts aimed at increasing physical activity, reduction in tobacco use, improved dietary choices. They may be focused on the entire state or community or on groups within the community.

Standards for Access to Critical Health Services

Standard 1

Information is available at both the state and local level that describes the local health system, including resources critical for public health protection and information about health care providers, facilities and support services.

> The state and each community should determine a specific set of critical health services, but a basic recommended core set includes prevention and intervention services, primary care, prenatal care, family planning services, oral health care, emergency medical care, immunizations, nutrition services (WIC), well-child care, tuberculosis screening and follow-up, other communicable disease response, and environmental health protection.

Standard 2

Information is collected, monitored and disseminated regarding trends that, over time, affect access to critical health services.

Standard 3

Plans to reduce specific gaps in access to critical services are developed and implemented through collaborative efforts.

Standard 4

Regulatory requirements for delivery of health care services and capacity, process, and outcome measures regarding critical health services are established, monitored, and reported.

Appendix 5: Information Technology

Washington State Data Available in VISTA

Measure

Population estimates

Fertility rates

Abortion and pregnancy rates

Birth risk factors

Infant mortality

Birth risk factors for infant mortality

Mortality

Life expectancy

Hospitalizations

Communicable disease

Tuberculosis

Sexually transmitted diseases

Cancer incidence

Sources of Data

1990 U.S. Census

Department of Social and Health Services

Office of Financial Management

Birth certificate data

Death certificate data

DOH Office of Hospital and Patient Data Systems

DOH report records

Washington State Cancer Registry

Washington State Notifiable Conditions*

Conditions (Suspected or Confirmed) Notifiable to Local Health Departments Immediately

Animal Bites
Botulism (foodborne, infant, and wound)
Brucellosis (Brucella species)
Cholera
Diphtheria
Disease of suspected bioterrorism origin (including anthrax and smallpox)
Disease of suspected foodborne origin (disease clusters only)
Disease of suspected waterborne origin (disease clusters only)
Enterohemorrhagic E. coli such as E. coli 0157:H7 Infection
Haemophilus influenza (invasive disease, children under age 5)
Hemolytic uremic syndrome
Hepatitis A (acute infection)
Listeriosis
Measles (rubeola)
Meningococcal disease
Paralytic shellfish poisoning
Pertussis
Plague
Poliomyelitis
Rabies (including the use of post-exposure prophylaxis)
Relapsing fever (borreliosis)
Rubella (including congenital rubella syndrome)
Salmonellosis
Shigellosis
Tuberculosis
Typhus
Yellow fever
Other rare diseases
Unexplained critical illness or death

Conditions (Confirmed) Notifiable to Local Health Departments within 3 Work Days

AIDS
Campylobacteriosis
Chancroid
Chlamydia trachomatis infection
Cryptosporidiosis
Cyclosporiasis
Encephalitis, viral
Giardiasis
Gonorrhea
Granuloma inguinale
Hantavirus pulmonary syndrome
Hepatitis B (acute infection)
Hepatitis B surface antigen+ pregnant women
Hepatitis (infectious), unspecified
Herpes simplex, neonatal and genital (initial infection only)
HIV
Legionellosis
Leptospirosis
Lyme Disease
Lymphogranuloma venereum
Malaria
Mumps
Psittacosis
Q Fever
Serious adverse reactions to immunizations
Streptococcus, Group A (Invasive Disease Only)
Syphilis
Tetanus
Trichinosis
Tularemia
Vibriosis
Yersiniosis

Conditions (Confirmed) Notifiable to Local Health Departments on a Monthly Basis

Hepatitis B (chronic)—Initial diagnosis, and previously unreported prevalent cases

Hepatitis C—Initial diagnosis, and previously unreported prevalent cases

*Required to be reported by health care providers in Washington State.

Appendix 6: Workforce Training Needs Assessment Summary

Introduction and Methods

The Washington State Department of Health has contracted with the University of Washington School of Public Health and Community Medicine's Northwest Center for Public Health Practice (NWC) to undertake activities to increase the competency of the public health workforce in Washington to perform essential services of public health. These services include responding to possible acts of bioterrorism, development of informatic systems, and improved ability to meet the state's Proposed Standards for Public Health.

NWC began this work with an analysis of three training needs assessment activities undertaken in the state of Washington during the past three years. In late June 2000, the NWC supplemented this work by conducting 15 key informant interviews with public health leaders identified by leadership groups. Key informants were asked to identify the most important areas of training needed by the state's public health workforce in the next 2-5 years in order for public health agencies to meet the proposed performance standards. They were also asked what training is already in place to address the identified priority areas.

Priority training areas

1. Communication Skills

The majority of the key informants specified communicating with the community/external constituents as the primary need. Key informants also stressed the need for a continuing priority on improving internal communications. They focused on the need for team-building and interdisciplinary work. All the key informants recognized that communications were at the core of success in achieving the performance standards and in their everyday work. The high priority placed on the role of communication skills in conveying the performance standards to community audiences is an additional nuance to the earlier assessments.

2. Community Involvement/ Mobilization

Key informants related the need for training in community involvement/ mobilization and mentioned the role played by community partnerships in health improvement. They directly linked the need for a priority on community involvement with the implementation of the Proposed Standards for Public Health, recognizing the level of interaction needed to receive attention if the standards were to be credible and the process respected. The relationship between achievement of standards and improved community health status was implicit in these discussions.

3. Policy Development/Planning

The following two comments typify the key informant responses in this area:

> "Local health departments are good at gathering data, but poor at translating the data to policy makers; we need to understand the policy process."

> "Health departments are good at analyzing; the weak link here is taking assessments and converting them to policy."

Key informants noted that the linkage between communication and policy was essential in "sharing the performance standards with decision-makers and presenting data to achieve the standards."

4. Teaching/Training

Key informants particularly recognized the importance of the information-sharing role of health departments. Several informants linked this area with the communication priority. They placed a priority on developing training opportunities that will create the capacity at the state and local level to make better use of staff as trainers and, in the words of one informant, as "consultants" to internal and external audiences.

5. Cultural Skills

The majority of key informants prioritizing this area commented that cultural skills mean more than working with minority populations. They involve, in the words of one informant, the "need to understand the values, culture, and concerns of the community we serve." This suggests a broader approach to future training in cultural skills, and as in all of the other areas, is closely linked with other priority training areas—especially community mobilization and communication.

Training Opportunities

Most of the key informants agreed that there are many specific training opportunities available, but most have limitations. They may be specific to technical areas or directed at broader communication and analysis. They often aren't tailored to the public health professional—or, because they aren't more centrally organized—they place the onus on state and local health supervisors to find the training most appropriate for their staff. Concern was also expressed that training is often very expensive, both in actual training costs and in travel and leave time for staff.

Gaps in Training

The most frequently mentioned areas in which it was difficult to find training resources were the broad categories of organizational change and workforce development (including provision of training to people in the workforce about how to advance in their careers, leadership development, and quality improvement), policy development, and social marketing. Key informants generally agreed that much of the current training is expensive and either too specific or too general. Many informants felt that distance learning addressed the shortcomings of other modalities—expense, staff travel and release time, and number of staff who could partake of the training.

Communicable Disease Control, Informatics, and Bioterrorism

Several key informants mentioned the need for the development of policies and protocols relating to surveillance systems and communicable disease outbreak management. The need for basic training in communicable disease outbreaks and related infrastructure issues was also a priority.

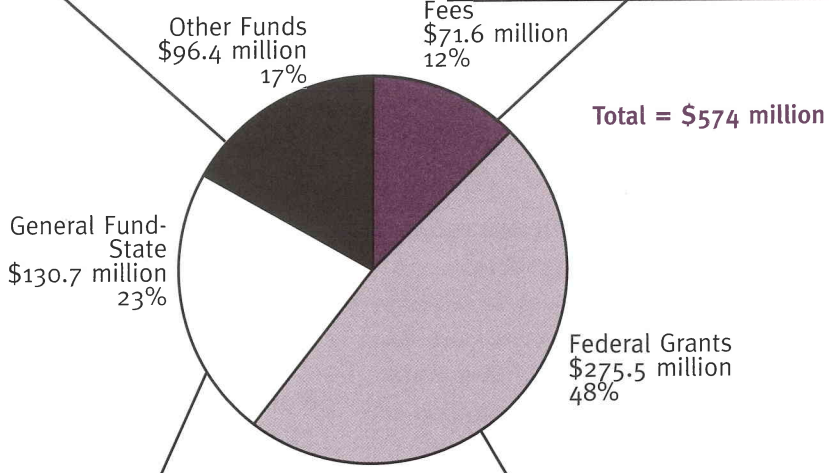
Comments related to informatics reinforced for the NWC the fact that this term refers as much to basic computer competency as it does to advanced technological systems. The training package currently under development by the NWC (addressing both informatics and bioterrorism/communicable disease control) is consistent with these findings.

The full report on workforce training needs is available on the NWC web site: http://healthlinks.washington.edu/nwcphp/ waphtn.

Appendix 7: Department of Health Revenues by Source, 1999-2001

Other Funds	
WIC rebates	$44.2
Trauma care	14.9
Health services—for local capacity	13.0
Water quality	3.3
Toxics control	2.8
Youth tobacco prevention	1.8
Tobacco prevention	15.6
All other	0.8
	$96.4

Fees	
Health professions licensing	$37.5
Newborn screening	6.6
Hospital commission	2.4
Drinking water—operating permits	2.5
Air emissions monitoring	2.0
Construction review of facilities	1.0
Hospitals	1.6
Medical test site	1.2
Vital records	1.2
Radioactive materials	1.3
X-ray compliance	1.6
Other	12.7
	$71.6



Local Pass-through	
AIDSNETs	$16.3
Local capacity funding	3.5
Maternal and child health	9.7
Emergency medical and trauma	9.3
WIC	3.2
Rural health	1.0
Other	1.4
	$44.4

Support for "Direct Client Services"	
Vaccines	$15.1
Family planning	9.6
HIV client services/prescription drugs	3.1
Breast and cervical cancer	2.0
	$29.8

General Fund-State	
Local pass-through	$44.4
Support for client services	29.8
State programs	38.3
Agency, division administration	18.2
	$130.7

General Fund "State Programs"	
Laboratory	$7.3
Other	4.6
Emergency medical and trauma	3.4
Shellfish	3.9
Maternal and child health	4.4
Epidemiology	2.5
Office on AIDS	2.0
Center for Health Statistics	2.5
Rural health	1.2
Pesticides	1.0
Wastewater	1.5
Child care center certification	1.0
Food protection	0.6
Drinking water	1.4
Temporary worker housing	1.0
	$38.3

Of the total DOH budget for the 1999-2001 Biennium, DOH passes about $54 million per year to local health jurisdictions. DOH also passes funds to community-based and regional agencies. Local health jurisdictions also receive funds from other state agencies.

Federal	
WIC	$166.2
MCH	17.6
Breast and cervical screening	5.6
HIV care—Ryan White	16.7
Immunizations	7.1
AIDS prevention	5.7
Drinking water SRF	5.3
Family planning	5.4
Safe drinking water	4.9
STD project	3.7
AIDS surveillance/seroprevalence	5.7
Preventive health block grant	4.6
Tuberculosis	2.5
Tobacco use prevention and control	2.3
Title 18 certification	1.5
Other	20.7
	$275.5

Appendix 8: A Conceptual Framework and Approach to Measuring Access to Critical Health Services

The Proposed Standards for Public Health in Washington State, in the section addressing Access to Critical Health Services, measures state performance under Standard 1 as follows: "Information is collected and disseminated about the availability of a core set of critical health services that are necessary to protect the public health."

The State Board of Health undertook an effort to list critical health services and then consider how access to those services might be measured at a state or local level. Measurement of access to critical health services raises questions of definition and context. There is no single, standard approach to measuring access. For the most part, information necessary to gauge the actual need for services is not routinely collected. Recognizing that measuring access would require a number of developmental steps, the State Board of Health considered a framework that illustrated one approach to measurement and outlined key considerations that could be used in determining how information systems might be adapted in the future. They are presented here as a guide to future work.

Key Considerations and Their Applicability to Critical Health Service Measurement in Washington State

Purpose of measurement

To provide baseline information on access to critical health services and to track, over time, improvements in access to those services. This information is intended to support local health jurisdictions in their work of community mobilization to improve access. It can also assist in state-level purchasing and policy development.

Level of aggregation

Service data will need to be sufficiently distinct (e.g., screening services versus educational services versus intervention services) to support local gap analysis, and these data must break down by county/local health jurisdiction.

Burden of measurement

The goal is to minimize burden of measurement to the extent possible, whether on local jurisdictions, state agencies, health plans, or providers.

Population(s) of interest

Breakdown by target populations, age, gender, ethnicity, or other population variables is desirable, if possible.

Composite of public and private delivery system

Information from public and private delivery systems is critical, and comparability of data is a long-term goal.

Sustainability of measurement

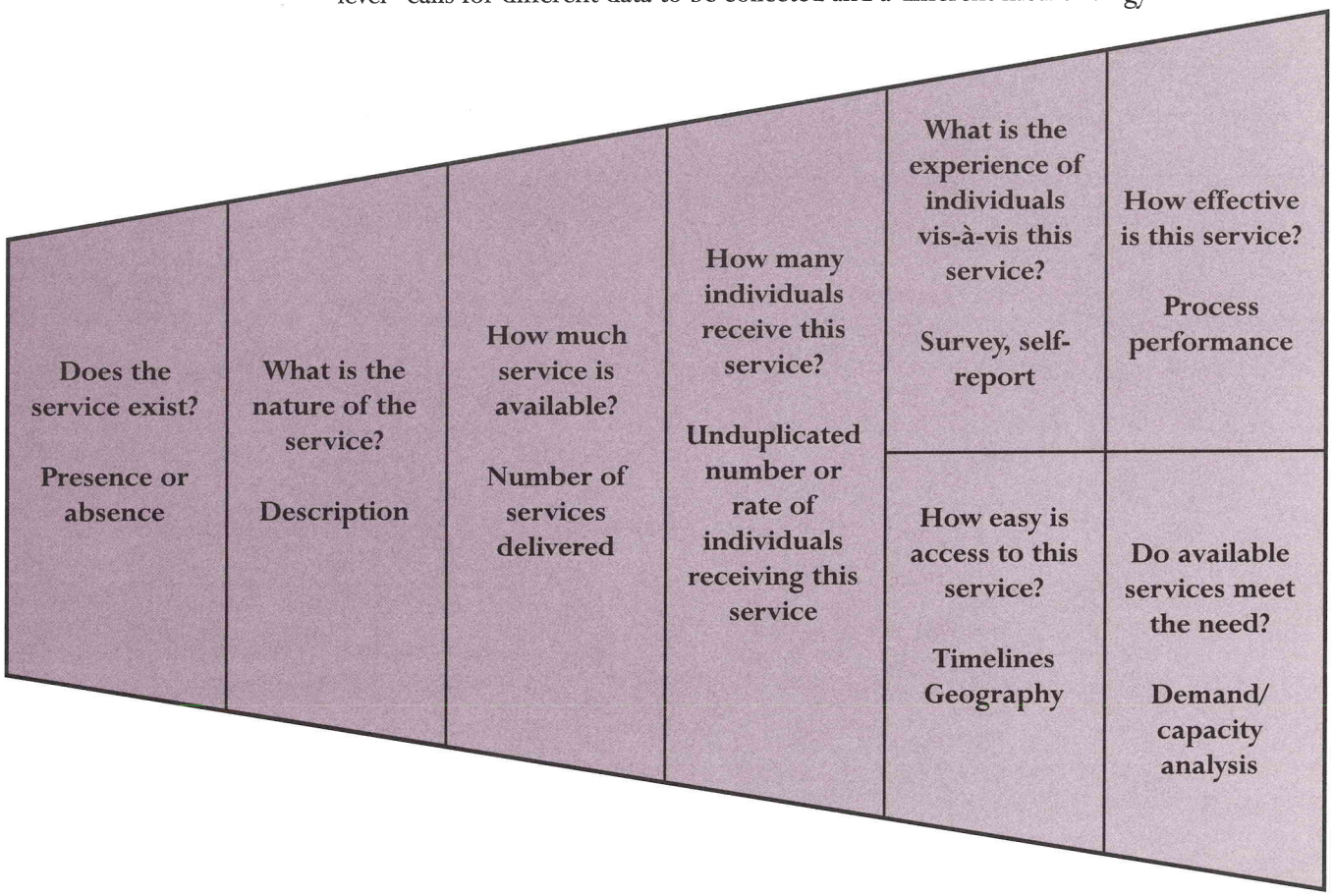
The intention is to build a system of measurement for access to critical health services that will be managed and sustained over the long term.

Appropriateness of service

This consideration, while very important, is not within the scope of the initial measurement process.

Measuring Access: A Continuum of Questions

This figure portrays a range of questions that can be asked when seeking information about access to health services. Progressing along this range, from left to right, leads to increasing information or insight into the nature of access to services. This suggests an approximate hierarchy of approaches to collecting data on access. Each question or "level" calls for different data to be collected and a different methodology.



The *2000 Public Health Improvement Plan* summarizes the work of many people who have joined efforts in committees and work groups. More detailed, full reports are available.

To obtain copies of this report, or copies of committee reports, please contact:

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