

**Performance Review of  
Standards for Public Health  
in Washington State**

**2008 Overall System Report**

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# **Performance Review of Standards for Public Health in Washington State**

## **2008 Overall System Report**

DOH Pub 822-016 1/2009

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HEALTHIER WASHINGTON

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## MORE PERFORMANCE REVIEW REPORTS AVAILABLE ONLINE

*(All reports in the following three sections are not included in this report, but can be found online at [www.doh.wa.gov/phip/PerfMgmt/07stds/08PR/reports.htm](http://www.doh.wa.gov/phip/PerfMgmt/07stds/08PR/reports.htm))*

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# Executive Summary

## The Standards

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

### 12 Standards for Public Health

- Community Health Assessment
- Communication
- Community Involvement
- Monitoring and Reporting Threats
- Planning for Emergencies
- Prevention and Education
- Addressing Critical Health Services
- Program Planning and Evaluation
- Financial and Management Systems
- Human Resources Systems
- Information Systems
- Leadership and Governance

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

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

## Site Visit Preparation and Process

Eight performance reviewers, two from LHJs and six from DOH, were trained in 2007 to conduct portions of the site review for the performance standards. In the fall of 2007, the MCPP consultants provided 11 half-days of training for DOH and LHJ staff and managers to help them prepare for the performance review.

Site reviews were conducted from March through May 2008. Each site review concluded with a closing conference in which general strengths and opportunities for improvement were discussed and feedback on the standards and assessment process was obtained. In total, 34 LHJs, the State Board of Health, and 20 DOH program sites were reviewed.

## Program Reviews

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



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

### **Comparison to the 2005 Review**

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

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

### **Overall System Performance**

Three common themes can be drawn from the 2008 snapshot of system performance. First, the system works as well as it does because of the skills and commitment of the staff and the scope and depth of work being done to improve the health status of Washington State residents. Second, since the 2005 performance review, DOH and some LHJs made significant investments to address the results of the 2005 performance review and to improve the public health system. Third, many of the local and DOH programs were only able to partially demonstrate performance due to failure in completing the Plan-Do-Study-Act (PDSA) cycle of improvement (e.g., planning activities and implementing them, but not studying the effectiveness or impact of the activities or taking action on the results).

### **Overall Performance Findings**

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

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

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

### **Findings Specific to the Standards**

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

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

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

## Relationship of Performance to Annual Budgets and Number of Employees

As in previous standards review cycles, analysis was conducted to determine if, and what, correlations exist between performance of the standards and both budget and FTE levels in local jurisdictions. As expected, some jurisdictions with larger budgets or more FTEs did demonstrate higher performance of some of the measures. In other words, more resources did lead to high performance. However, the relationship between overall LHJ performance and annual budgets and FTEs did not show a clear correlation between the size of the LHJ and the demonstrated performance. There is variability in performance that indicates that performance, while connected to budget and size, also has other drivers.

## Recommendations

Recommendations are made to assist local and state agencies in developing meaningful approaches to address deficiencies and capitalizing on opportunities. Please refer to page 19 for the full recommendations that are highlighted below.

- **Closing the Plan-Do-Study-Act Cycle**

Many of the local and state programs were only able to partially demonstrate performance due to a failure to complete the Plan-Do-Study-Act (PDSA) cycle of improvement (e.g., planning activities and implementing them, but not studying the effectiveness or impact of the activities or taking action on the results of monitoring program performance measures). Several recommendations related to specific areas that need “closure of the PDSA loop” are described below. (Please refer to p. 1 for a more complete description of the PDSA cycle and refer to Recommendations 1 and 2 of Standard 8 related to Program Planning and Evaluation.)

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

- **Community Involvement in the Review of Data and Recommending Action**

Standard 3 also showed lower performance for measures **3.1** and **3.2** at both the local and state level. These measures also relate to closing the PDSA loop as the review and use of data to inform community recommendations for action also reflect the Study and the Act steps of the PDSA improvement cycle.

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

- **Process to Identify New Licensees**

Measure **4.1** for both LHJ and DOH programs showed lower performance due to the inconsistency in processes to identify new licensees. Most of the LHJs have a process for distributing notifiable conditions information to providers, but many do not have processes to identify the new licensees in their communities.

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

- **Emergency Preparedness and Response Plan (EPRP) Orientation and Training**

Measure **5.5L** and **S** had low performance in 2005 and again across the public health system in this 2008 review.

***Recommendation for Standard 5:** LHJs and DOH should consistently orient new staff to the EPRP and conduct annual review of the EPRP for all staff in the agency.*

- **Review of Prevention and Health Education Information**

Measures **6.3L** and **S** requires the review of all types of educational materials at least every other year. This was another area with low performance in 2005 as well as this performance review.

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

- **Program Planning and Evaluation**

While more agencies and programs at both the state and local level demonstrated the establishment of program goals, objectives and performance measures than in 2005, this is still a system-wide area needing improvement. Standard 8 continues to have the lowest level of performance (34% demonstrated) at the local level as demonstrated through the review of 100 programs. In DOH programs, the performance in several measures in Standard 8 showed meaningful improvement, but more than 25% were not able to demonstrate the tracking, analysis, and use of monitoring performance measures. Improvement efforts should be expanded by:

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

Measures **8.1L** and **S** and **8.2L** and **S** are a prime arena to demonstrate “closing the PDSA loop” by tracking, analyzing and using program specific performance measures. There are numerous examples of exemplary practices at both the local and state level that should be used by lower performing programs to improve.

***Recommendation 1 for Standard 8:** All programs in LHJs and DOH strengthen their focus and initiatives to establish and monitor performance measures and use the results to improve programs and services.*

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

Measure **8.7L** and **8.9S** - Only about 25% of the DOH programs and less than 20% of local programs were able to demonstrate that they conduct annual audits of program activities for timeliness and compliance with protocols.

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

- **Customer Service Standards**

Measures **8.5L** and **S** require that customer service standards be established for all employees that interact with the public, stakeholders and/or partners and that measures for these standards be identified and evaluated. At the local level, only 24% of LHJs were able to demonstrate that they had established and evaluated customer service standards for those staff that interact with the public. The DOH agency partially demonstrated this measure.

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

- **Performance Evaluations with Training Plans**

Measures **10.2L** and **S** require that performance evaluations are conducted routinely and include training plans that are updated annually. This measure was partially demonstrated by the DOH agency, and only 18% of LHJs were able to demonstrate the measure.

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

- **Standards Needing the Most Improvement in LHJs**

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

- Standard 3 related to community involvement in review of data and taking action
- Standard 8 related to program planning and evaluation
- Standard 9 related to ensuring budgets are aligned with strategic plans and to conducting contract monitoring

- Standard 12 related to board of health (BOH) functions, strategic planning, and quality improvement activities

***Recommendation for Standard 12:***

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

• **Standards Needing the Most Improvement in DOH**

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

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

**Recommendations for the Next Performance Improvement and Review Cycle**

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

***Recommendation:***

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

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

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



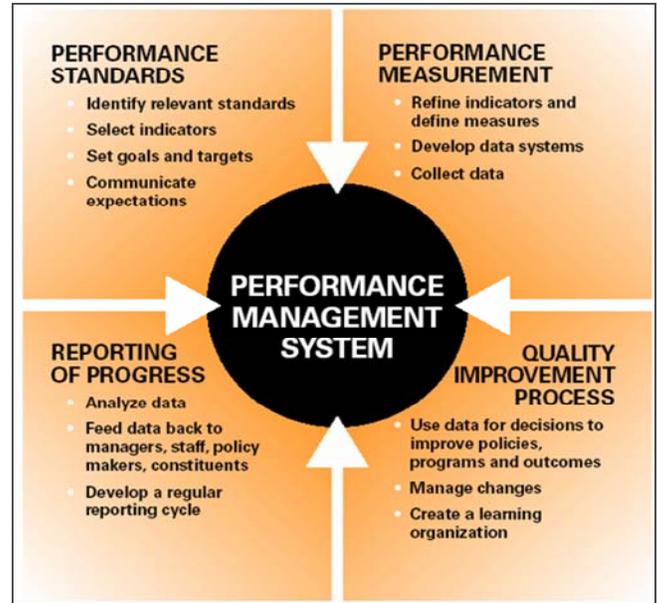
# Background and Approach to the Performance Review

## THE WASHINGTON STATE STANDARDS FOR PUBLIC HEALTH

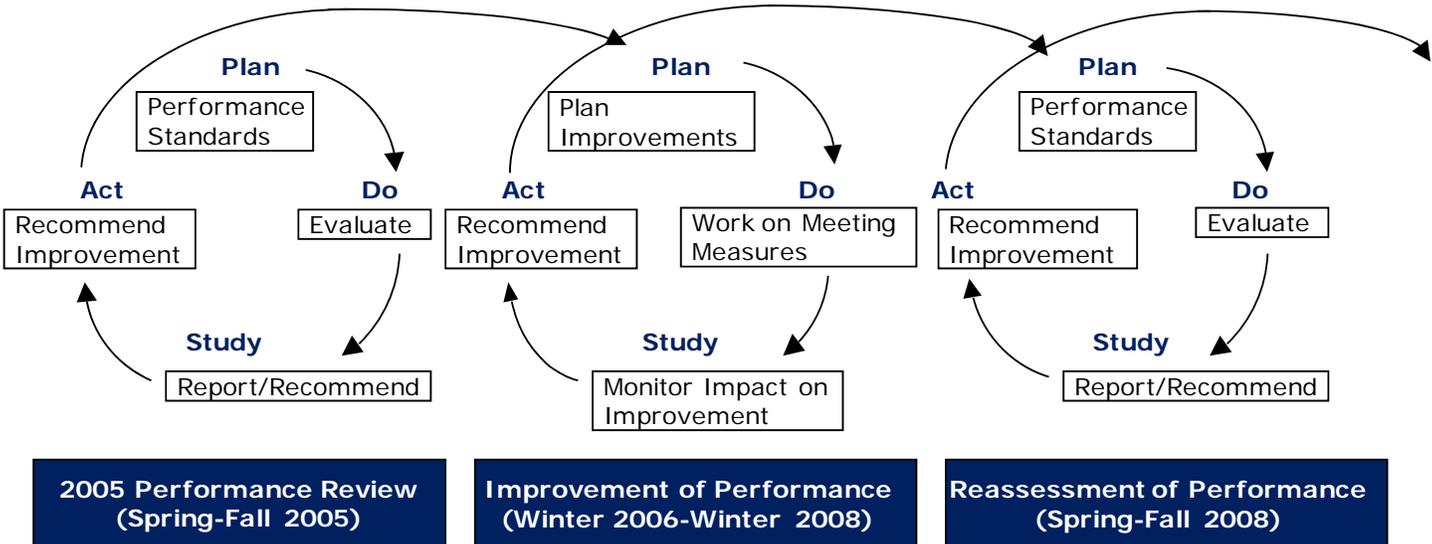
The Standards for Public Health in Washington State were developed collaboratively by local and state public health staff in 1999 and have been used every three years to review the public health system in Washington. A baseline measurement was conducted in 2002 and re-measurement was conducted in 2005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

An important part of the Standards for Public Health in Washington State is the 3-year performance review cycle and the results from the review which inform our work. Also critical to the process is the implementation of continuous quality improvement efforts into the review process. The 3 years leading up to each review cycle (the time since the previous cycle) includes many necessary activities, which follow the Plan-Do-Study-Act quality improvement cycle.

The standards development and measurement process uses the Shewhart Quality Improvement cycle. The performance standards, trainings, and preparation documents are included in the *Plan* step; the improvement activities are the *Do* step; site visits, data analysis, and this report are the *Study* step; and the future work on system improvement and revision of the standards will be the *Act* step.



The following diagram describes the 2005 performance review (the first re-measurement after the 2002 baseline), the interim two-year improvement work and the current 2008 performance review (second re-measurement) cycles.



The standards review work is conducted under the auspices of the Public Health Improvement Partnership (PHIP) and is guided specifically by the Performance Management Committee. This report summarizes the 2008 performance review site visit process, findings, and recommendations. For more information about the development of the standards and the context of the national activities for measuring and improving the public health system, go online for the history which is available at [www.doh.wa.gov/hip/PerfMgmt/07stds/08PR/reports.htm](http://www.doh.wa.gov/hip/PerfMgmt/07stds/08PR/reports.htm).

In 2006 the standards were rewritten and reorganized so that the requirements are clearer and there is less duplication. (See [Appendix C](#)) This resulted in about 40% fewer measures than in 2005. A crosswalk between the former [2005] standards and the current standards is available online at [www.doh.wa.gov/hip/documents/perfmgmt/material/reverselookup.xls](http://www.doh.wa.gov/hip/documents/perfmgmt/material/reverselookup.xls).

The Standards for Public Health in Washington State are 12 statements that describe expected performance for public health work. For each standard, specific measures tell how the performance will be measured. Because of differing roles, there is a set of measures for local health jurisdictions and a separate set for the state agencies and programs, including the State Board of Health and Department of Health. The Standards for Public Health in Washington State encompass the core public health functions, the nationally recognized 10 Essential Services, and the NACCHO operational definition of a health department. The crosswalk of the Washington standards to these other frameworks is available online at [www.doh.wa.gov/hip/documents/perfmgmt/material/nacchocrosswalk.xls](http://www.doh.wa.gov/hip/documents/perfmgmt/material/nacchocrosswalk.xls)

The taxonomy for the standards and/or measures is as follows, **2.3L** refers to:

- **2** = the standard (*Public information is a planned component of all public health programs and activities. Urgent public health messages are communicated quickly and clearly.*)
- **3** = the specific measure (*Urgent information is provided through public health alerts to the media and to key stakeholders.*)
- **L** = local jurisdiction measure

A corresponding *measure* for a State program would be numbered **2.3S** (**2** = standard, **3** = measure, **S** = state).

The 2008 review included administrative standards (standard 9 through standard 12) that were developed in 2004 and field tested in 2005. The results in this report for standards 9 – 12 are the baseline measurement.

## **STANDARDS THAT MEASURE AND “STRETCH” THE STATEWIDE PUBLIC HEALTH SYSTEM**

Because the results of system performance review are used primarily for improving overall performance, the standards themselves are not intended to describe the system as it currently operates. The standards articulate a higher level of performance, often described as “stretch standards” or what should be in place. It is important to understand that the standards and measures are not all currently attainable by all parts of the system. Stretch standards provide a higher bar for performance that remains stable over the course of several review cycles and provides for comparison of results.

## **PERFORMANCE REVIEW APPROACH**

The performance review process was conducted under the direction and oversight of the PHIP Performance Management Committee with the assistance of a consultant team from MCPP Healthcare Consulting, Inc. During the fall of 2007, the consultants provided 11 half-days of training for DOH and LHJ staff and managers to help them prepare for the performance review. The training content included the context and the content of the public health standards, preparation for the site review, and a mock review exercise.

Eight performance reviewers—two from LHJs and six from DOH—were trained to conduct portions of the site review for the performance standards. The use of additional reviewers builds internal expertise in the

interpretation of the performance measures, in methods for conducting the review, and experience in other parts of the public health system. All reviewers participated in inter-rater reliability sessions to increase the consistency of the performance reviews.

## APPLICABILITY OF MEASURES

The standards apply to all public health programs/activities conducted at the state or local level; however, not all measures under a standard apply to all programs/activities. More than half of the measures apply to the agency level of the LHJ, with fewer than half applying to LHJ programs and activities. (See the LHJ Applicability Matrix at [www.doh.wa.gov/phip/documents/perfmgmt/material/stdsappmatrix.xls](http://www.doh.wa.gov/phip/documents/perfmgmt/material/stdsappmatrix.xls), LHJ tab). The State Applicability Matrix identifies which measures apply to which programs/activities within the SBOH and DOH and can also be seen at [www.doh.wa.gov/phip/documents/perfmgmt/material/stdsappmatrix.xls](http://www.doh.wa.gov/phip/documents/perfmgmt/material/stdsappmatrix.xls), State tab.

There are three ways a measure can apply:

**Agency** - The measure applies to the agency (rather than individual programs) at either the local or state level. However, meeting the measure may require the participation of many or all programs/activities within the organization. The measure is demonstrated only once at a central point in the agency (an example is human resources).

**All** - These measures apply to every program/activity, whether or not listed in the matrix. Each program/activity must show individual demonstration of the measure.

**X** - These measures apply to specific programs/activities. Please see the LHJ or State Applicability Matrix to identify the programs or activities that are marked "X."

The applicability matrices do not identify which programs/activities will be evaluated in any cycle of performance review, but rather show the entire complement of programs that might be delivered and which measures apply to each program. Please go to [Appendix A](#) and [Appendix B](#) for the results and detailed information on all of the standards and measures.

## LHJ PROGRAMS REVIEWED

In this cycle, specific LHJ programs were selected for review. These same programs were also reviewed at DOH to create a system-wide "look" at these programs. Local and state leadership and the Performance Management Committee made the final selection of the programs for review. Programs were selected because of heightened activity or interest in these programs: communicable disease, immunization, and nutrition and physical activity are a focus for the E2SSB 5930 work; First Steps, tobacco and zoonotics have funding challenges and both food safety and wastewater management programs are of interest because of the Local Public Health Indicators work.

Every LHJ's communicable disease program was reviewed. Each LHJ also selected one environmental health program and one prevention/promotion program to be reviewed from the list below:

Table 1

Communicable Disease	Environmental Health Programs	Prevention/Promotion Programs
(Notifiable conditions activities only)	<ul style="list-style-type: none"> <li>Food safety</li> <li>Wastewater management</li> <li>Zoonotics</li> </ul>	<ul style="list-style-type: none"> <li>First Steps</li> <li>Immunization</li> <li>Nutrition and physical activity</li> <li>Sexually transmitted disease</li> <li>Tobacco</li> </ul>

The LHJ Applicability Matrix was used to identify the measures that were to be assessed through program review (see [www.doh.wa.gov/phip/documents/perfmgmt/material/stdsappmatrix.xls](http://www.doh.wa.gov/phip/documents/perfmgmt/material/stdsappmatrix.xls)). There are reports for the system-wide results for those programs that were selected by more than 5 LHJs. The analysis includes LHJ and DOH performance. These reports can be found at [www.doh.wa.gov/phip/PerfMgmt/07stds/08PR/reports.htm](http://www.doh.wa.gov/phip/PerfMgmt/07stds/08PR/reports.htm).

## STATE PROGRAMS REVIEWED

The Senior Management Team of the DOH identified programs to be reviewed within DOH. These were selected from the State Applicability Matrix of all the programs including all the programs on the LHJ menu above (see [www.doh.wa.gov/phip/documents/perfmgmt/material/stdsappmatrix.xls](http://www.doh.wa.gov/phip/documents/perfmgmt/material/stdsappmatrix.xls), State tab) For 2008 the programs reviewed in DOH were:

Table 2

Division	Prevention/Promotion Programs
Community and Family Health	Maternal infant health (First Steps), child and adolescent health, immunizations, tobacco, cancer (breast and cervical health), chronic disease prevention (nutrition and physical activity), Steps to a Healthier US, tuberculosis, HIV, sexually transmitted disease
Environmental Health	Food safety, radiation protection, zoonotics, wastewater management
Epidemiology, Health Statistics and the Public Health Laboratory	Public health laboratory, non-infectious conditions epidemiology, communicable disease epidemiology
Health Systems Quality Assurance	Community and rural health, facilities and licensing

## SITE CONTACTS AND PREPARATION

Each LHJ and DOH site was asked to identify a contact for their site. This person served as a point for communication and also, in some cases, assumed responsibility for coordinating the preparation for the site review.

Each LHJ and DOH program was provided with the Guidelines for Assessment of the Standards for Public Health in Washington State 7 to 9 months before the targeted submission date, and the guidelines were used as part of the mock review during the review preparation training sessions. These documents are available at [www.doh.wa.gov/phip/PerfMgmt/07stds/08PR/08tools.htm](http://www.doh.wa.gov/phip/PerfMgmt/07stds/08PR/08tools.htm). The guidelines state the specific requirements and some examples of documentation for each measure. LHJ and state-level sites were requested to submit their completed guidelines tool electronically to the review team approximately one month before their scheduled performance review.

## THE SITE VISIT PROCESSES

The site review process included all 35 LHJs some combined due to administrative or operational structure), the State Board of Health, and 20 DOH program sites selected by DOH to be reviewed along with the DOH agency. This system-wide review, conducted from March through May 2008, provides a “snapshot” of the entire system.

Prior to each visit, the performance reviewers scanned the completed guidelines submittal from that site and noted questions or concerns for follow-up. Once the performance reviewers arrived at a site, they

briefly met with appropriate staff to provide an overview of the survey process. They then reviewed the documents selected by the site to demonstrate performance of the measures. If the reviewer had questions or needed more documentation, an informal interview was conducted with the appropriate staff.

A closing conference was conducted as part of every performance review with general areas of strengths and opportunities for improvement discussed with the managers and staff. In addition, the conference provided an opportunity for sites to discuss any ideas or concerns about the standards and the performance review process.



# Data Analysis Methodology

Data collection was accomplished using a database created in Microsoft Access® to allow the performance reviewers to record scores and enter information for each measure for both state-level and LHJ reviews. The database recorded the following:

- The degree to which the site demonstrated performance regarding the measure (see scoring)
- Any comments from the performance reviewers that would help sites to understand the scoring or what might be needed to improve performance of the measure
- The documentation that was reviewed to score the measure
- The documentation that was requested for further review as a potential exemplary practice

The following guidelines were used for scoring:

- **Demonstrates (2)** — The documentation addressed all the requirements of the measure. For example, for LHJ measure **4.5L**: *A notifiable conditions tracking system documents the initial report, investigation, findings and subsequent reporting to state and federal agencies*, documentation must show each requirement of the measure (the initial report, investigation, findings, and subsequent reporting) to be scored as **Demonstrates**.
- **Partially Demonstrates (1)** — If some of the requirements were met, but not all, then the measure was scored as **Partially Demonstrates**.
- **Does Not Demonstrate (0)** — If the site provided no documentation to meet the measure, or if the documentation did not meet any of the requirements of the measure, then the measure was scored as **Does Not Demonstrate**.
- **Not Applicable** — Some measures were determined to be Not Applicable for some local or state-level programs. For example, in LHJs all measures were applicable; however, some were not applicable if an event had not occurred (for example, those that required certain actions related to an outbreak). These measures were scored **Not Applicable** and are not included in these analyses.

The data was analyzed and overall scores were calculated based upon the percent of **Demonstrates**, **Partially Demonstrates**, and **Does Not Demonstrate** scores for each program and agency for each measure. All measures assessed as **Not Applicable** were excluded from the calculation. The primary calculations used in analysis were the percent demonstrates for each agency overall and for each standard.

Using SPSS version 16.0, descriptive statistical tests were applied to the data. Pearson's product-moment correlation coefficient was applied to examine the relationship between LHJ overall performance and budget (2007 Budget, Accounting, and Reporting System [BARS] data) and FTE counts.

Confidence intervals were calculated to determine whether a statistically significant difference exists in the performance on select measures between 2005 and 2008. Only measures that were substantially equivalent in wording and review method were used for this analysis; only a few measures were identified as having statistically significant change, whether positive or negative, between the two review cycles.



# Overall System Performance on the Standards

The Standards for Public Health in Washington State were restructured and significantly revised in 2006. This restructuring focused the individual standards on a specific area of public health practice. This made overall performance on topic areas in earlier cycles non-comparable to performance in the individual standards in this 2008 cycle. For findings specific to individual measures, some comparisons were still possible and analysis for statistically significant change was conducted on about two dozen measures. These findings are reported below.

The revised standards also clarified and, in some cases, raised the performance “bar.” This means that the 2008 results must be interpreted with the understanding of the higher level of required performance. The expanded and more detailed guidelines used in 2008 further stipulated the requirements of each measure, resulting in requirements for some measures being more clearly stated than in previous cycles.

The Standards for Public Health in Washington State are organized into 12 standards. The measures are applicable to either the entire agency (local or state) or to the programs conducted in the agency. For example, the measures that address public information and media relations are applicable to the entire agency, while the measure regarding staff training is applicable to all programs within the agency. Findings are reported separately for LHJs and for the state (DOH agency, DOH programs, and State Board of Health) and summarized in charts in the appendices of this report.

## OBSERVATIONS REGARDING OVERALL SYSTEM PERFORMANCE

**Dedicated and Skilled Staff**—The system works as well as it does because of the skills and commitment of the staff and the scope and depth of work being done to improve the health status of Washington State residents.

**Investments in Improvement**—It was clear to the performance reviewers that, in the three-year period between the 2005 performance review and this 2008 review, DOH and some LHJs made significant investments to address the results of the 2005 performance review and improve the public health system. These include investments in:

- Implementation of technology and information systems, especially the communicable disease database Public Health Issues Management System (PHIMS) that has been implemented in all LHJs
- Development of the Local Public Health Indicators reports that collected, analyzed and reported county-level health outcomes on 28 indicators
- Establishment of a statewide improvement initiative funded by the Robert Wood Johnson Foundation (RWJF) through their multi-state collaborative focused on three major efforts:
  - Identify and track quantifiable performance measures in all programs
  - Conduct quality improvement projects in LHJs and DOH
  - Conduct three statewide improvement collaboratives to address priority issues

**Closing the Plan-Do-Study-Act (PDSA) Loop**—Many of the local and DOH programs were only able to partially demonstrate performance due to failure in completing the PDSA cycle of improvement (e.g., planning activities and implementing them, but not studying the effectiveness or impact of the activities or taking action on the results of monitoring program performance measures).

**Overall Performance Findings**—In the summary analysis that follows there is a focus on the 50th percentile, in which the midpoint is envisioned as a fulcrum where the weight falls toward demonstrated performance, improvement may still be needed, but the system is heading in the right direction—and

where the weight falls towards no or partially demonstrated performance—these areas will require significant planning and assistance to fully demonstrate performance.

- **State**—The SBOH and DOH agencies and programs were able to demonstrate an average of 71% of the measures in all the standards. Their performance was demonstrated as follows:
  - Three standards, including Standards 1, 3, and 6 had more than 50% of the state-level agencies and programs able to demonstrate performance on every measure.
  - Just one or two measures in Standards 2, 4, 5, 7, 9, 10, 11 and 12 had fewer than 50% of the programs able to demonstrate performance.
  - Standard 8 had three measures with fewer than 50% of programs able to demonstrate performance.
  - Almost half the state-level measures were “agency” measures that were reviewed once. There were 42 measures with 95% or higher demonstrated performance.
- **Local Health Jurisdictions**—LHJ results show a similar range of overall demonstrated performance in 2008 as in 2005 with 83% to 24% of measures demonstrated (2005 range was 86% to 21%). Average demonstrated performance was 56% of all LHJ measures in 2008 compared to 55% in 2005. Other highlights of local health department performance:
  - One LHJ increased demonstrated measures by 69%, compared to their 2005 performance. Another LHJ dropped in demonstrated measures by 46%.
  - 14 LHJs increased the percent of measures they were able to demonstrate and 17 decreased in percent demonstrated compared to the percent of demonstrated measures in 2005.
  - Out of the 76 performance measures for LHJs, only four measures had 95% or more LHJs able to demonstrate performance, as follows:
    - 1.7L** - When appropriate, there is collaboration with outside researchers engaging in research activities that benefit the health of the community.
    - 2.1L** - Communication activities include increasing public understanding of the mission and role of public health.
    - 2.9L** - Written policies, local ordinances, permit/license application requirements, administrative code, and enabling laws are available to the public.
    - 4.5L** - A notifiable conditions tracking system documents the initial report, investigation, findings and subsequent reporting to state and federal agencies.
  - One measure had only 6% of LHJs able to demonstrate performance (measure **12.9L** regarding the implementation of a written quality improvement plan).
  - There were no measures where no LHJ was able to demonstrate performance.

## FINDINGS SPECIFIC TO THE STANDARDS

### Summary of 2008 Performance: Local Health Jurisdictions

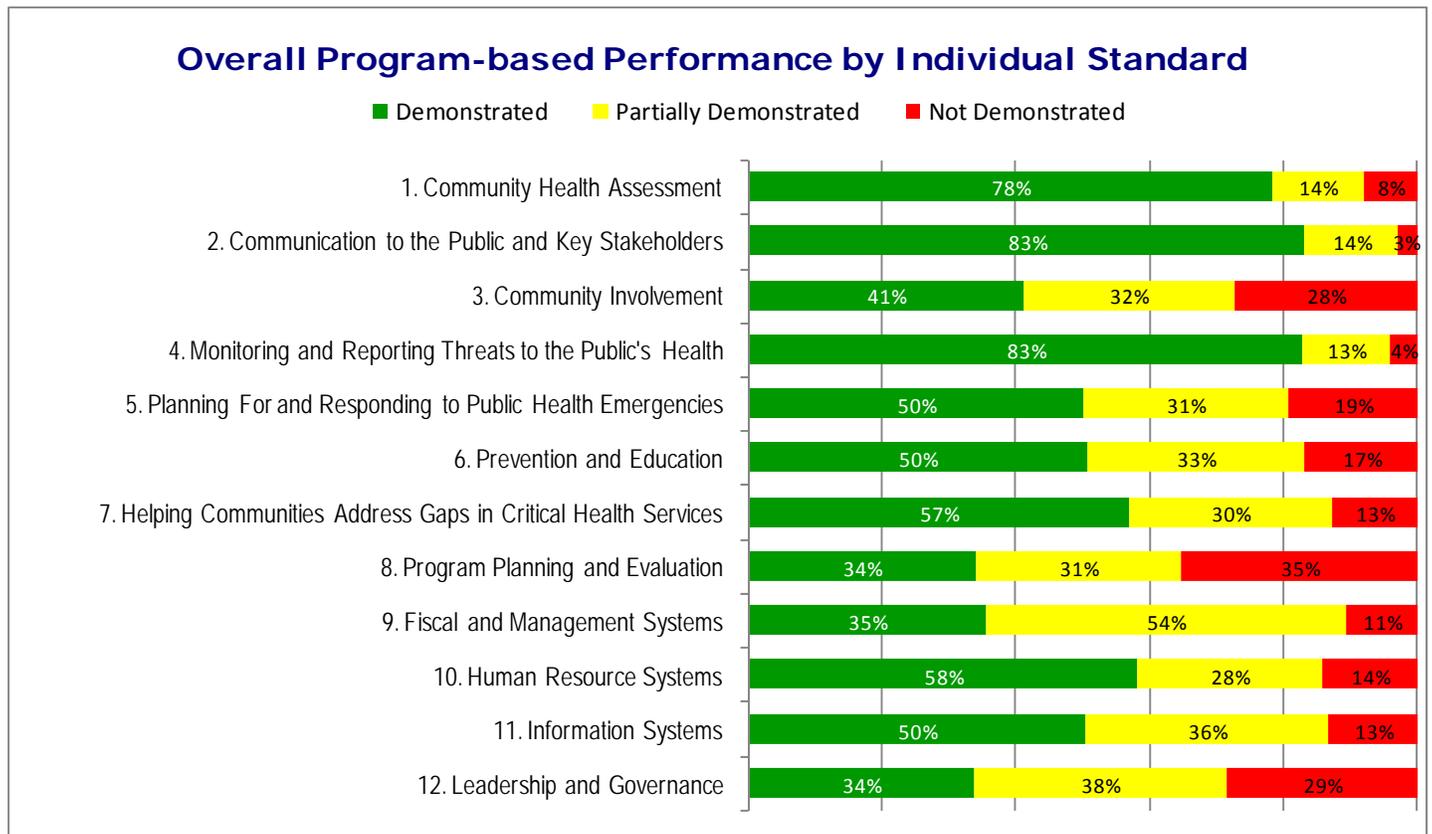
The aggregate LHJ performance results were analyzed using two different methods.

**Method A**, shown in Chart 1, aggregates all the individual local program performance results reviewed at the local level and shows the performance in all programs across the state, as well as the results for agency review measures. This program-based method is important as it reflects performance at the program level indicating the percent of all programs that were able to demonstrate each of the program-review measures. This method provides good information for statewide improvement at the program level. This method is used for both the LHJ Chart 1 and the State Chart 2 in the next section.

**Method B**, shown in Table 3, is an analysis of LHJs based on the agency-level scores for each measure. In Method B, for program-review measures a single LHJ score was calculated based on the performance of the programs in each LHJ. This LHJ-based method indicates the level of consistency in demonstrating performance in each LHJ and provides information for LHJs to focus their improvement efforts on measures where not all of their programs were able to demonstrate the measure.

An example of the differences in results for these two methods is shown in Standard 3. In the **Method A**—program-based method—Chart 1 (below) where all 100 local programs are included in the analysis, the percent demonstrated is 41%. This means that 41 of the 100 programs reviewed across all LHJs were able to demonstrate the two measures in Standard 3. In the table for **Method B**—LHJ-based method—the single measure score for each of the LHJs was analyzed (n=33). In this instance, only 13% of the 33 LHJs received a demonstrated score, meaning that all three programs in those LHJs demonstrated both measures which are evaluated through program review. For standards with fewer program review measures (like Standard 1), the performance percentages are much closer in the two methods.

Chart 1



- Method A**—program-based method (shown in Chart 1) aggregates the scores for all the LHJ programs that were reviewed to determine the average demonstration level by standard. The performance percentages are a raw aggregation of all the scores for each measure and these vary depending on whether the measure is an agency review measure that is reviewed once for each LHJ where the n=33 or the measure is reviewed by evaluating the selected programs, where the number of scores aggregated for the measure can vary from 33 (if just one program was reviewed like the CD program for some measures in Standard 4) to 100 programs (if all three programs were evaluated for that measure like **10.4L** regarding staff training). Rounding creates totals that are not exactly 100%.

Table 3

### LHJ-based Performance Using Agency Scores

Standard	Demonstrates	Partially Demonstrates	Does Not Demonstrate
Standard 1	78%	14%	8%
Standard 2	75%	23%	2%
Standard 3	13%	76%	10%
Standard 4	82%	14%	4%
Standard 5	59%	29%	12%
Standard 6	39%	54%	7%
Standard 7	57%	30%	13%
Standard 8	24%	58%	18%
Standard 9	35%	54%	11%
Standard 10	50%	36%	14%
Standard 11	50%	36%	13%
Standard 12	34%	38%	29%

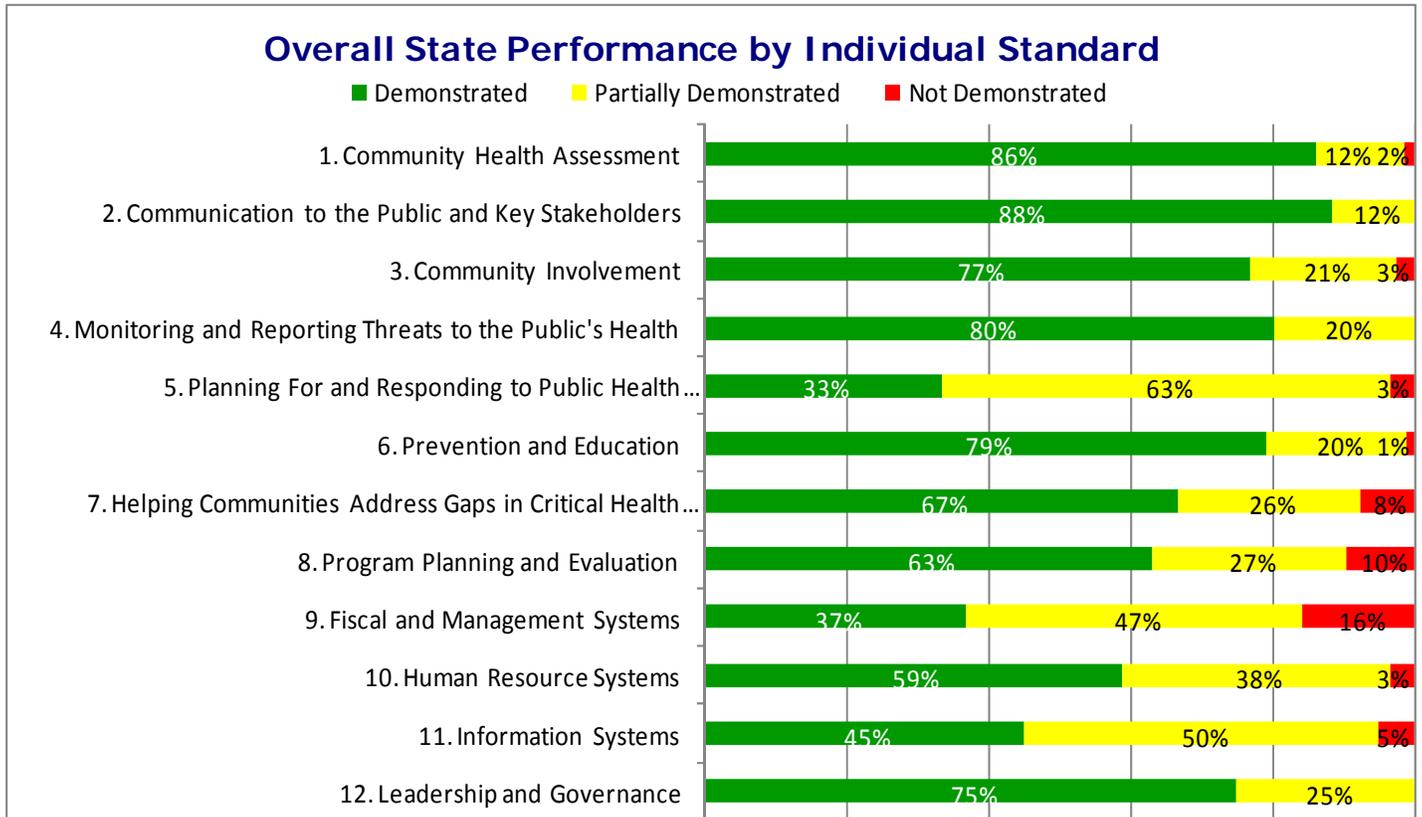
**Method B**—LHJ-based method (shown in Table 3) reflects the performance reported in the LHJ site-specific reports where the program scores for each measure are calculated as a single score for the agency. For example, **Method B** indicates the measure was “**Demonstrated**” for the LHJ only if all the program scores for that measure are demonstrated. These results, like **Method A**, include both agency review and program review measures.

An example of the differences in results between **Method A** and **Method B** can be demonstrated using Standard 3. In the **Method A** chart (previous page), where all 100 local programs are included in the analysis, the percent demonstrated is 41%. This means that 41 of the 100 programs reviewed across all LHJs were able to demonstrate the measures in Standard 3. In the table for **Method B** the single measure score for each of the LHJs was analyzed (n=33). In this instance only 13% of the 33 LHJs received a demonstrated score, meaning that all three programs in those LHJs demonstrated both measures which are evaluated through program review. For standards with fewer program review measures (like Standard 1) the performance percentages are much closer in the two methods.

#### Summary of 2008 Performance: State (DOH agency, DOH programs, and SBOH)

The following chart shows the average demonstration level by standard for the DOH agency, the DOH programs, and the SBOH. There were nine measures where no DOH program was able to demonstrate performance (**2.2S**, **4.1S**, **4.3S**, **5.4S**, **8.5S**, **10.2S**, **10.3S**, **12.2S**, and **12.6S**). Only one or two sites were evaluated for these measures and, therefore, results are based on very small numbers. Overall results by standard are displayed below.

Chart 2



## RELATIONSHIP OF PERFORMANCE TO ANNUAL BUDGETS AND NUMBER OF EMPLOYEES

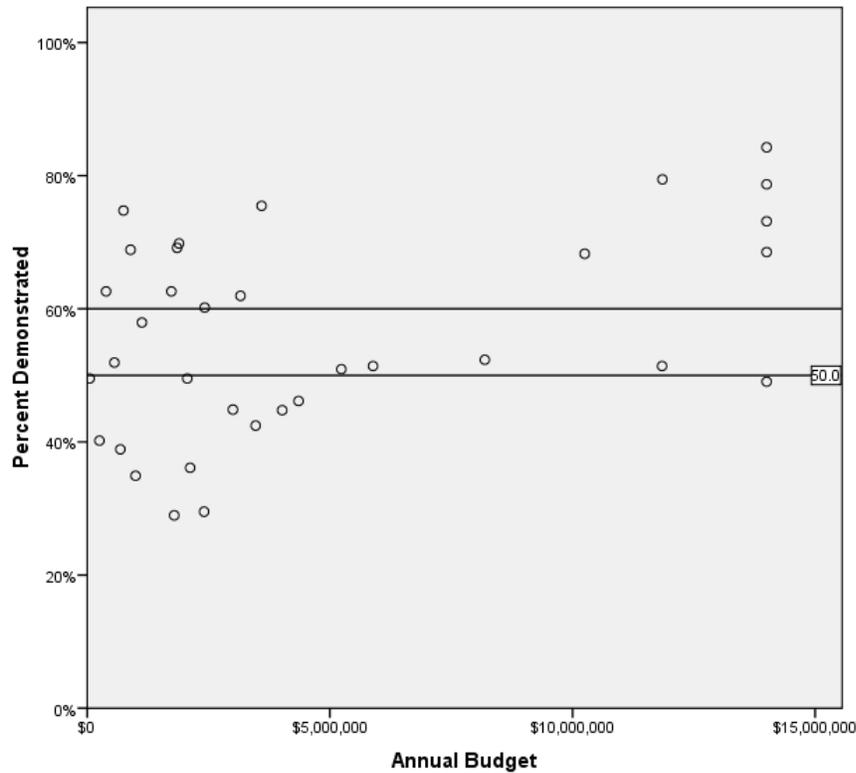
Analysis was conducted to determine if and what correlations exist between performance on the standards and both budget and FTE levels in local jurisdictions. As expected, some jurisdictions with larger budgets or more FTEs were more likely to demonstrate higher performance on some of the measures. But money isn't the only thing that matters. In fact, the relationship between overall LHJ performance and annual budgets and FTEs is nearing random at best. As in the two earlier performance review cycles, there was no clear correlation between the size of the LHJ and the demonstrated performance. We also conducted analyses of the per capita LHJ budget to overall performance and of the per capita LHJ FTEs to overall performance. Neither analysis showed any significant correlation between per capita dollars or FTEs and overall LHJ performance. There is variability in performance that indicates that performance, while connected to budget and size, also has other drivers. Field observation suggests these include:

- Engagement and investment of managers and staff in improvement of agency work processes and increasing performance in the standards;
- Local leadership and priority setting as demonstrated by the development of strategic plans linked to the standards and tied to performance data;
- Local funding levels as demonstrated by focused use of Local Capacity Development Funds (LCDF) and pursuit of grant funding for special program initiatives;
- Staff skill, training, and experience, particularly in program management, as demonstrated through programs with goals, objectives, and performance data; and
- Documentation and data systems as demonstrated by protocol development, local performance data, and use of data as part of community planning efforts.

Additionally, the system-wide improvement initiatives (such as implementation of the PHIMS database and numerous state and local quality improvement projects) increased the capacity and activities that demonstrate performance.

Chart 3

### Correlation of LHJ Overall Performance and 2007 Annual Budget\*



(All budgets over \$14,000,000 are displayed as \$14,000,000)

**\*Note:** The darker circles in the graph above denote where two LHJs' 2007 budgets are almost the same causing the data points to overlap

Of the group of 12 LHJs demonstrating performance on 60% or more of the 76 local measures, five (42%) are smaller LHJs with budgets of between \$400,000 and \$1.9 million annually.

Specific exemplary practices often reflected locally focused resource allocation (for example, targeted use of LCDF or staff expertise) or state program structures and financing that focused efforts in program planning and evaluation. These specific exemplary practices were found in LHJs of all sizes and were not necessarily related to overall performance or budget/FTE size.

In summary, while analysis gives us some associated factors with success, it cannot be said with certainty that these factors are causative nor does it identify other possible factors related to performance but not measured or observed in this analysis. Several different analyses of budget and FTE correlations to performance were conducted. There is a positive correlation between the size of a local jurisdiction budget and/or number of employees and the likelihood of demonstrated performance on 4% or 3 of the 76 measures in 2008. This is fewer measures than this same analysis showed in 2005 when there was positive correlation for 16 of the 91 LHJ measures or 18% of the measures. Only one measure showed a high correlation between budget and the ability to demonstrate performance—measure **12.10L** regarding the annual evaluation and revision of the agency's quality improvement plan and demonstrating improvement in at least one objective.

## Demonstrated Performance for LHJs by Peer Group

Each local health agency has received a site-specific report as a foundation for continued improvement efforts. The LHJ reports contain separate individual scoring for each of the three selected programs and a single, aggregated score for the measure at the agency-wide level for each of the measures assessed through program review. Also for LHJs, in addition to seeing the scores for each measure at the end of each standard, there is a roll-up of the scores on all applicable, scored measures in the standard (the percent of measures scored as demonstrates, the percent scored as partially demonstrates, the percent scored as does not demonstrate). Next to the roll-up for the standard is a roll-up for peer counties and then a statewide LHJ roll-up for comparison purposes. A summary table showing how LHJs were grouped for the purpose of analysis in this report is shown below and is available along with explanations of the methodology and rationale from the Department of Health's website [www.doh.wa.gov/Data/Guidelines/RuralUrban.htm](http://www.doh.wa.gov/Data/Guidelines/RuralUrban.htm).

Table 4

### Peer Groups for Performance Assessment Analysis

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

The method used provides a more textured way of analyzing differences than a simple urban/non-urban split. There is no intent in this improvement-focused effort to compare specific LHJs to one another. However, this roll-up data does provide each LHJ site with performance benchmarks.

- LHJs in all four peer groups demonstrated more than 70% of measures in Standard 1 (assessment activities), Standard 2 (communication with the public and stakeholders), and Standard 4 (monitoring and reporting threats to the public's health). These three areas indicate a consistently higher level of performance than in other standards. Current activities need to be maintained and improvement targeted in specific sites or on lower-performing activities.
- LHJs in all four peer groups demonstrated more than 50% but less than 70% of measures in Standard 9 (fiscal and management systems) and Standard 10 (human resource systems). These two areas show more consistent levels of performance, but need improvement activities targeted in the LHJs that demonstrate lower performance.

- Several standards had consistently low aggregate performance with 50% or fewer LHJs demonstrating performance. These are Standard 3 (community involvement in review of data and taking action), Standard 8 (program planning and evaluation), and Standard 12 (related to board of health functions, strategic planning, and quality improvement activities). These three areas offer the most urgent need for improvement across all LHJs.
- The remaining standards had mixed performance by peer group as shown in the table below. These are areas of public health practice where the higher performers can provide model practices and improvement ideas to their colleagues in lower-performing LHJs to raise the performance across the state public health system.

Table 5

### Standards with Mixed Performance by Peer Group

Peer Group	Standard 5 demonstrated	Standard 6 demonstrated	Standard 7 demonstrated	Standard 11 demonstrated
Urban	55%	63%	68%	69%
Large Town	48%	45%	67%	47%
Mixed Rural	38%	51%	50%	49%
Small Town/ Rural	56%	39%	42%	42%

### COMPARISON OF 2008 PERFORMANCE TO 2005: LOCAL HEALTH JURISDICTIONS

The results described below are for the measures that were substantially equivalent in wording and review method in 2005 (about two dozen measures) and that also met the test of statistically significant change. The analysis indicates that significant improvement occurred in four LHJ measures between the 2005 and the 2008 results. While these four results are statistically significant, it is important to acknowledge meaningful improvement in performance which reflect strong interventions and sustained improvement in results.

#### Standard 2: Communication to the Public and Key Stakeholders

One measure in the Communication to the Public and Key Stakeholders standard showed significant improvement in performance between the 2005 and this 2008 review:

- **2.9L** (EH only, formerly EH **4.1L**) [*Written policies, local ordinances, permit/license application requirements, administrative code, and enabling laws are available to the public.*] A strong showing across the board by LHJs was noted with an increase in the proportion of LHJs demonstrating improvement from 88% to 100%.

#### Standard 4: Monitoring and Reporting Threats to the Public's Health

Three measures in the Monitoring and Reporting Threats to the Public's Health standard showed significant improvement in performance between the 2005 and 2008 reviews:

- **4.2L** (formerly CD **3.2L**) [*Health care providers receive information, through newsletters and other methods, about managing reportable conditions.*] A significant improvement—from 74% to 92% of LHJs demonstrating performance—was observed.
- **4.5L** (formerly CD **1.6L**) [*A notifiable conditions tracking system documents the initial report, investigation, findings and subsequent reporting to state and federal agencies.*] A significant improvement—from 82% to 100% of LHJs demonstrating performance—was observed.

- **4.8L** (EH only, formerly EH **4.4L**) [*A tracking system documents environmental health investigation/compliance activities from the initial report, through investigation, findings, and compliance action, and subsequent reporting to state and federal agencies as required.*] A significant improvement—from 67% to 94% of LHJs demonstrating performance—was observed.

## PROGRAM REVIEW RESULTS

Program reports were developed with the aggregate results for six of the nine programs reviewed at the local level. Three of the programs (nutrition and physical activity, STDs and zoonotics) had less than five programs reviewed, and the number was determined to be too small to report aggregate results. Specific program reports can be viewed at [www.doh.wa.gov/phip/PerfMgmt/07stds/08PR/reports.htm](http://www.doh.wa.gov/phip/PerfMgmt/07stds/08PR/reports.htm). The highlights of the findings for communicable disease and food safety programs (both with more than 16, or 50%, of LHJs) are included in this system report.

### Communicable Disease Program

All measures applicable to communicable disease activities were evaluated at 33 LHJs and for the DOH CD/Epi program. This gives us results for the performance of communicable disease across the entire state. The results showed:

- The DOH CD/Epi program demonstrated performance in 24 out of the 34 applicable measures, with an overall aggregate score of 71% demonstrated. Overall, LHJs demonstrated performance on 59% of the 23 applicable measures. The measures where DOH was able to demonstrate performance but the performance in the LHJs is not as strong presents an opportunity to collaborate for improvement .
- High performance (60% to 100% of programs able to demonstrate performance) was demonstrated by both local and DOH programs in nine measures:
  - Measures **2.8**, **2.9**, and **2.10** related to information being made available to the public about activities, educational offerings, and laws and regulations in various languages for diverse populations
  - Measures **4.4**, **4.5**, and **4.6** related to having protocols for receiving and managing information on notifiable conditions, and protocols for managing specific conditions and implementing a tracking system for notifiable conditions. These measures reflect the statistically significant improvement created through the implementation of the PHIMS database in all LHJs and the distribution of standardized condition protocols to LHJs by the DOH program.
  - Measure **6.4** regarding the range of methods used to implement population-based prevention and health education
  - Measure **8.3** regarding the use of additional information sources to improve services
  - Measure **10.4** that evaluated the extent of staff training
- Lower performance (fewer than 50% of programs able to demonstrate performance) was indicated for both local and DOH programs for four measures:
  - Measure **4.1**, with partially demonstrated performance by DOH and 48% demonstrated performance by local CD programs, relates to health providers and labs, including new licensees, being provided with information on notifiable conditions (NC). Most of the LHJs have some activities for providing providers with the NC information, but many do not have processes to identify the new licensees in their communities.
  - Measure **5.5**, with partially demonstrated performance by DOH and only 27% of local CD programs, relates to orientation and annual review of the EPRP.
  - Measure **8.2** regarding the tracking, analysis, and use of performance measures for CD activities
  - Measure **8.7L** and **8.9S** regarding the internal audit of CD investigations for timeliness and compliance with protocols

## Food Safety Program

The measures applicable to food safety activities were evaluated at 23 LHJs and for the DOH Food Safety program. This gives us results for the performance of food safety programs in 2/3 of the LHJs and the state. For the measures where DOH was able to demonstrate performance but the performance in the LHJs is not as high, there is an opportunity for collaboration for improvement. The results showed:

- The DOH Food Safety Program demonstrated performance in 24 out of the 28 applicable measures. Three measures that were partially demonstrated by DOH are:
  - Measure **4.8S** regarding the development and distribution of evaluation templates for response to disease outbreaks and other emergencies
  - Measure **5.5S** regarding the orientation and annual training of staff to the EPRP
  - Measure **6.3S** regarding the review of educational materials of all types at least every other year
- One measure was not demonstrated by DOH: measure **11.5S** regarding policies to guide data-sharing between agencies
- High performance (60% to 100% of programs able to demonstrate performance) was demonstrated by both local and DOH programs in six measures:
  - Measures **2.8**, **2.9**, and **2.10** related to information being made available to the public about activities, educational offerings, and laws and regulations in various languages for diverse populations
  - Measure **6.1** regarding identification of key food safety program components and development of strategies for education
  - Measure **8.1** regarding the establishment and tracking of goals, objectives, and performance measures
  - Measure **10.4** regarding staff training in required topics
- Lower performance (fewer than 50% of programs able to demonstrate performance) was indicated for both local and DOH programs for two measures:
  - Measure **5.5** regarding the orientation and annual training of staff to the EPRP
  - Measure **6.3** regarding the review of educational materials of all types at least every other year

# Recommendations

## IMPROVING PERFORMANCE OF THE PUBLIC HEALTH SYSTEM IN WASHINGTON STATE

The local health jurisdictions, the DOH agency and programs, and the State Board of Health have all received site-specific reports with their individual 2008 performance review results. The leadership at each of these sites is responsible for reviewing the results and identifying important areas for improvement. This report does not include recommendations for individual sites, but focuses on recommendations for overall public health system improvements.

In order to improve a system's performance, it is important to identify where standardization (reduction of unintended variation) benefits the system. In other words, where consistency results in more effective work processes and improved outcomes. It is also important to maintain customization (intended variation) to address different needs in populations and communities. The appropriate balance of standardization and customization is required to achieve high performance in all parts of a system.

The following recommendations are specific to the results of the 2008 performance review. An important tool in effectively implementing these recommendations is the 2008 Exemplary Practices Compendium that contains examples of processes and documentation that demonstrate performance of at least one requirement of a specific measure. Reviewers observed that among all the LHJs and state programs, the components of the "high performing" public health system are almost all present somewhere. They just don't exist together in any single LHJ or DOH program. Many examples of this exemplary public health system do exist, however, in the Exemplary Practices Compendium.

### Improvement Opportunities for Both the State and Local Agencies

- **Closing the Plan-Do-Study-Act Cycle**

Many of the local and state programs were only able to partially demonstrate performance due to a failure to complete the PDSA cycle of improvement (e.g., planning activities and implementing them, but not studying the effectiveness or impact of the activities or taking action on the results of monitoring program performance measures). Several recommendations related to specific areas that need "closure of the PDSA loop" are described below. (Please refer to p. 1 for a more complete description of the PDSA cycle and refer to Recommendations 1 and 2 of Standard 8 related to Program Planning and Evaluation.)

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

- **Community Involvement in the Review of Data and Recommending Action**

Standard 3 also showed lower performance for measures **3.1** and **3.2** at both the local and state level. These measures also relate to closing the PDSA loop as the review and use of data to inform community recommendations for action also reflect the Study and the Act steps of the PDSA improvement cycle.

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

- **Process to Identify New Licensees**

Measure **4.1** at both LHJ and DOH programs showed lower performance due to the inconsistency in processes to identify new licensees. Most of the LHJs have a process for distributing notifiable conditions information to providers, but many do not have processes to identify the new licensees in their communities.

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

- **Emergency Preparedness and Response Plan Orientation and Training**

Measures **5.5L** and **S** had low performance in 2005 and again across the public health system in this 2008 review.

*Recommendation for Standard 5: LHJs and DOH should consistently orient new staff to the EPRP and to conduct annual review of the EPRP for all staff in the agency.*

- **Review of Prevention and Health Education Information**

Measures **6.3L** and **S** require the review of all types of educational materials at least every other year. This was another area with low performance in 2005 as well as this performance review.

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

- **Program Planning and Evaluation**

While more agencies and programs at both the state and local level demonstrated the establishment of program goals, objectives, and performance measures than in 2005, this is still a system-wide area for improvement. Standard 8 continues to have the lowest level of performance (34% demonstrated) at the local level as demonstrated through the review of 100 programs. In DOH programs, the performance in several measures in Standard 8 showed meaningful improvement, but more than 25% of DOH programs were not able to demonstrate the tracking, analysis, and use of monitoring performance measures. Improvement efforts should be expanded by:

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

Measures **8.1L** and **S** and **8.2L** and **S** are a prime arena to demonstrate “closing the PDSA loop” by tracking, analyzing, and using program-specific performance measures. There are numerous examples of exemplary practices at both the local and state level that should be used by lower performing programs to improve.

*Recommendation 1 for Standard 8: All programs in LHJs and DOH strengthen their focus and initiatives to establish and monitor performance measures and use the results to improve programs and services.*

- **Conduct at Least Annual Internal Audits of Cases or Activities**

Measures **8.7L** and **8.9S** - Only about 25% of the DOH programs and less than 20% of local programs were able to demonstrate that they conduct annual audits of program activities for timeliness and compliance with protocols.

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

- **Customer Service Standards**

Measures **8.5L** and **S** require that customer service standards be established for all employees that interact with the public, stakeholders, and/or partners and that measures for these standards be identified and evaluated. At the local level, only 24% of LHJs were able to demonstrate that they had established and evaluated customer service standards for those staff that interact with the public. The DOH agency partially demonstrated this measure.

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

- **Performance Evaluations with Training Plans**

Measures **10.2L** and **S** require that performance evaluations are conducted routinely and include training plans that are updated annually. This measure was partially demonstrated by DOH agency; only 18% of LHJs were able to demonstrate the measure.

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

- **Standards Needing the Most Improvement in LHJs**

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

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

***Recommendation for Standard 12:***

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

- **Standards Needing the Most Improvement in DOH**

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

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

## **Recommendations for the Next Performance Improvement and Review Cycle**

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

***Recommendation:***

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

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

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

# Appendices



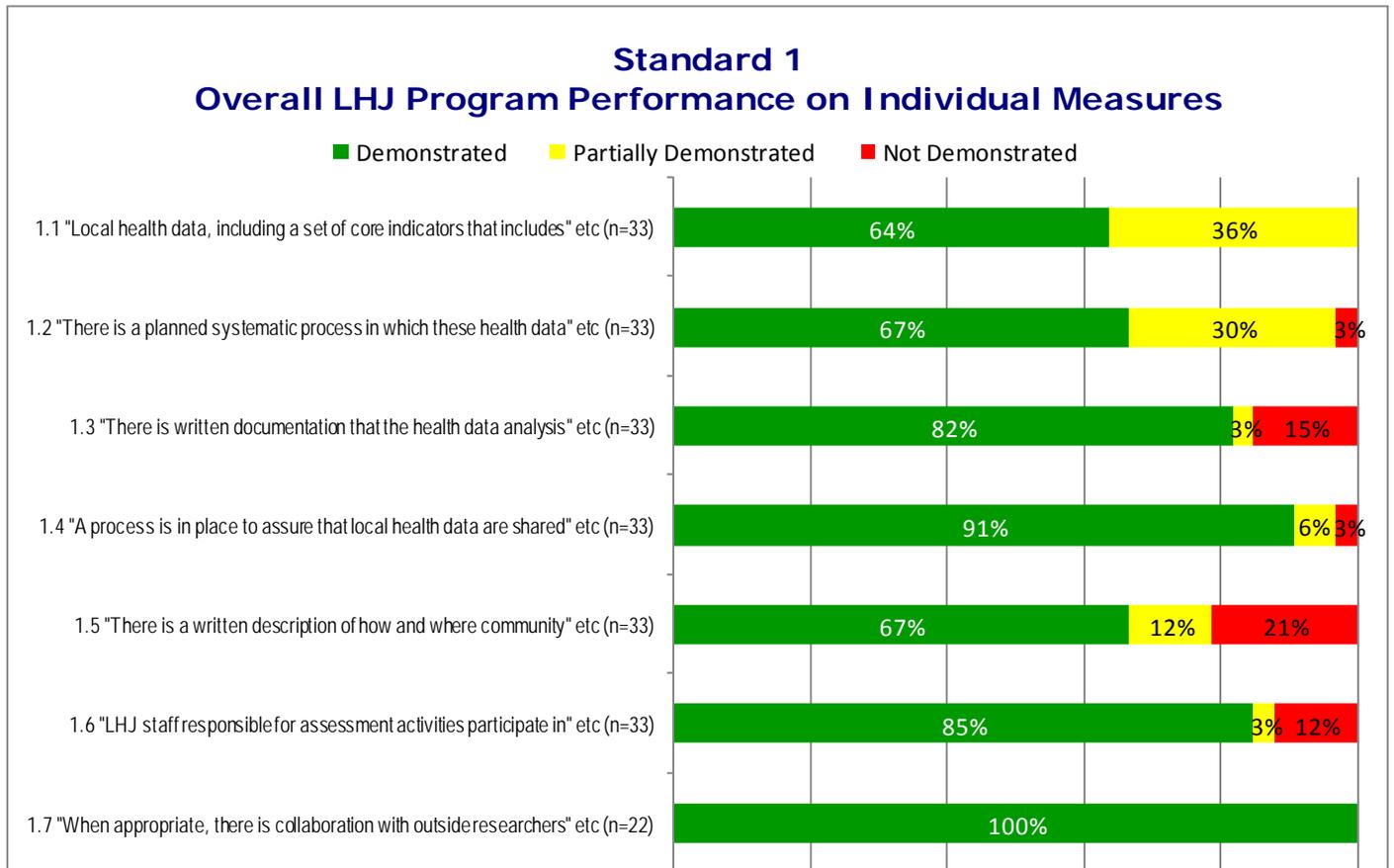
# Appendix A: Local Health Jurisdictions Results

## AGGREGATE ANALYSIS

### Standard 1: Community Health Assessment

Data about community health, environmental health risks, health disparities and access to critical health services are collected, tracked, analyzed, and utilized along with review of evidence-based practices to support health policy and program decisions.

Chart 4

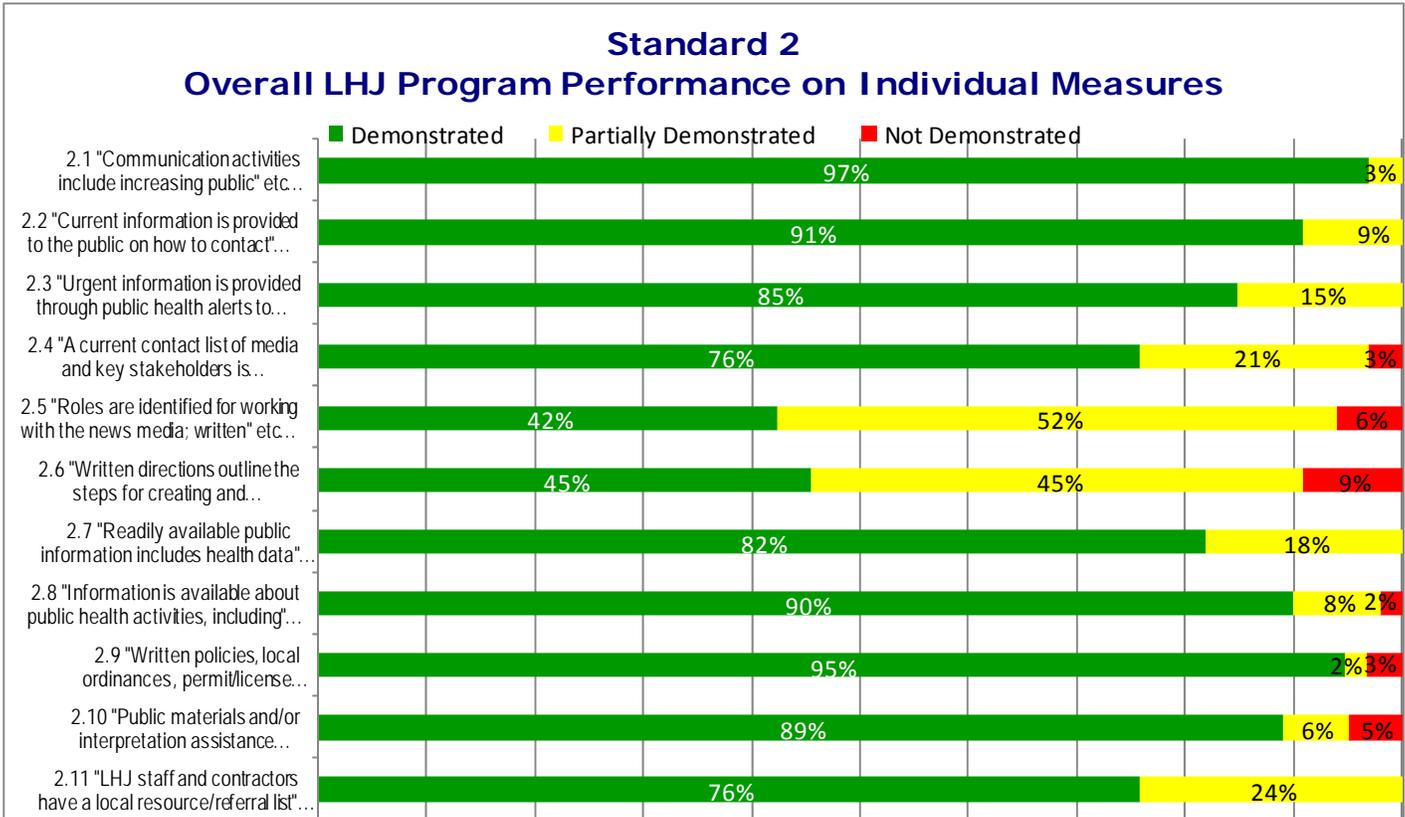


This standard has an aggregate percent demonstrated of 78% which is the third highest performance of a standard for LHJs in 2008. All of the measures had more than 50% of LHJs that were able to demonstrate performance. Measure **1.7L** regarding research activities was scored as either demonstrated or NA so the 100% demonstrated is for approximately 2/3 of LHJs that are engaged in research activities.

## Standard 2: Communication to the Public and Key Stakeholders

Public information is a planned component of all public health programs and activities. Urgent public health messages are communicated quickly and clearly.

Chart 5



This standard has an aggregate percent demonstrated of 83% which is tied with Standard 3 for the highest performance of a standard for LHJs in 2008. All but two of the eleven measures in this standard have 50% or more of the LHJs able to demonstrate performance.

### Statistically Significant Improvement

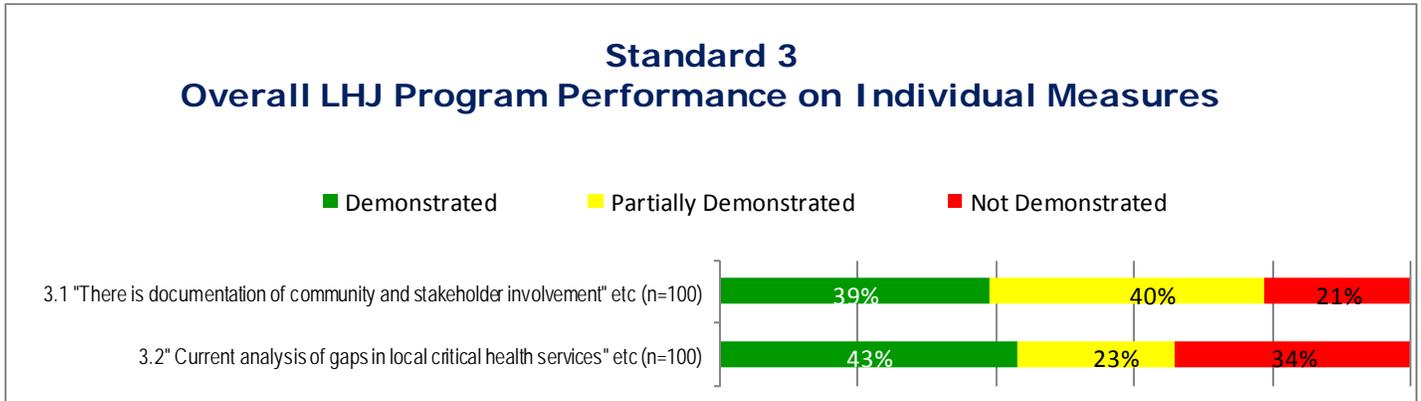
One of the measures in this standard that is comparable to a 2005 measure shows statistically significant improvement:

Measure **2.9L** "Written policies, local ordinances, permit/license application requirements, administrative code, and enabling laws are available to the public" had 88% demonstrated in 2005 and improved to 100% demonstrated in 2008. This is attributable to the increased internet access and website improvements that have occurred in the last three years at the local level throughout the state.

### Standard 3: Community Involvement

Active involvement of community members and development of collaborative partnerships address community health risks and issues, prevention priorities, health disparities and gaps in healthcare resources/critical health services.

Chart 6

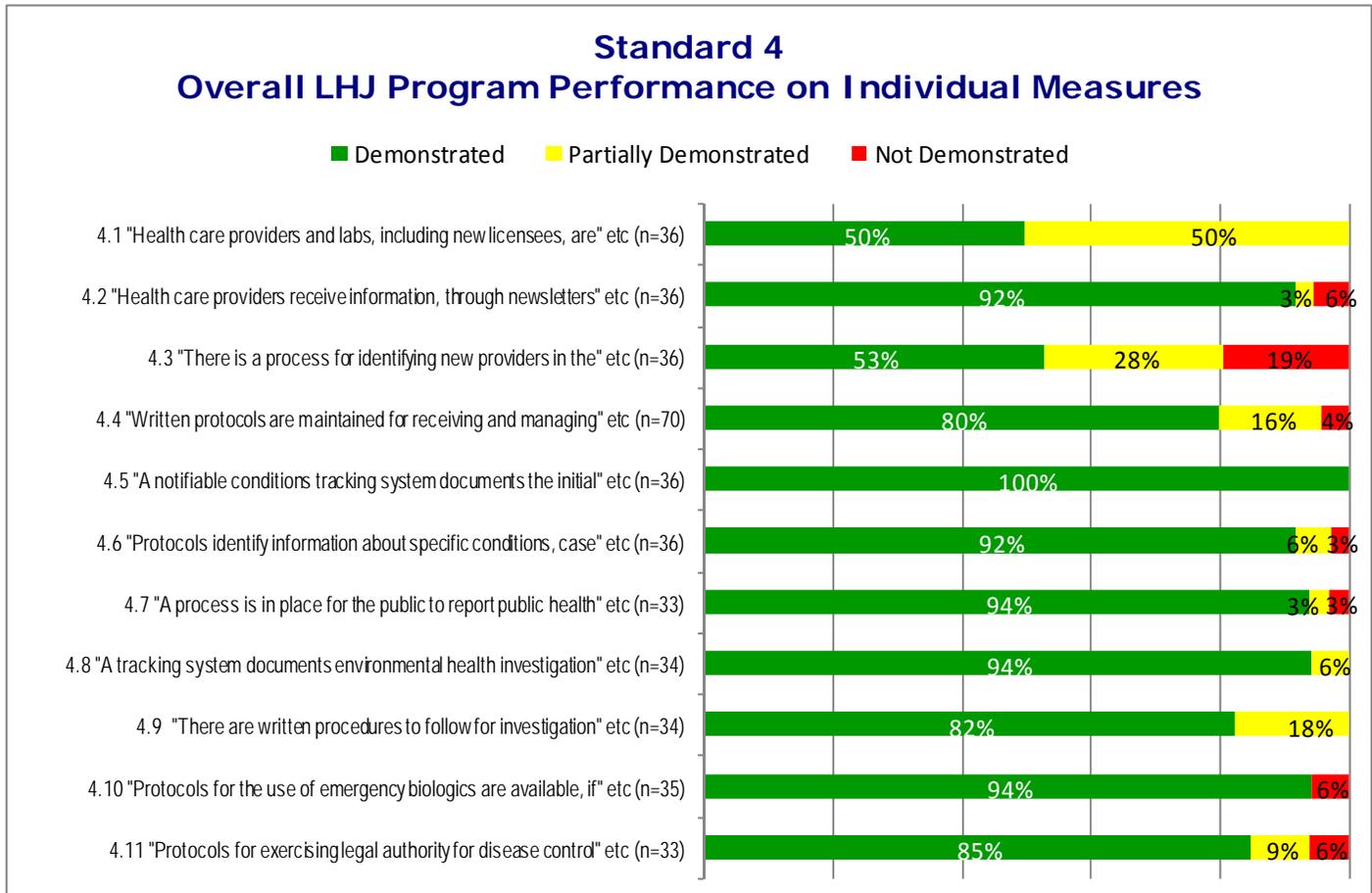


This standard has an aggregate percent demonstrated of 41% which is the fourth lowest performance of a standard for LHJs in 2008. Neither of the two measures in this standard has 50% or more of the LHJs able to demonstrate performance. These two measures evaluate community involvement in the review of local health data, including data about gaps in program effectiveness or prevention services, and recommend action to address the conclusions from the data. The lower performance in this standard is indicative of the failure to close the PDSA loop by reviewing data and information to draw conclusions and take appropriate action.

## Standard 4: Monitoring and Reporting Threats to the Public's Health

A monitoring and reporting process is maintained to identify emerging threats to the public's health. Investigation and control procedures are in place and actions documented. Compliance with regulations is sought through education, information, investigation, permit/license conditions and appropriate enforcement actions.

Chart 7



This standard has an aggregate percent demonstrated of 83% which is tied with Standard 2 for the highest performance of a standard for LHJs in 2008. All eleven measures in this standard have 50% or more of the LHJs able to demonstrate performance. Measures **4.1L** and **4.3L**, with just 50% and 53% demonstrated performance respectively, highlight the low performance on engaging current providers and identifying and engaging new providers regarding the requirements for reporting notifiable conditions. A related state-level measure that requires a DOH program to report new licensees to LHJs also has low performance. Together, these provide an excellent opportunity to improve this process at both the local and state level.

### Statistically Significant Improvement

Three of the measures in this standard that are comparable to 2005 measures show statistically significant improvement:

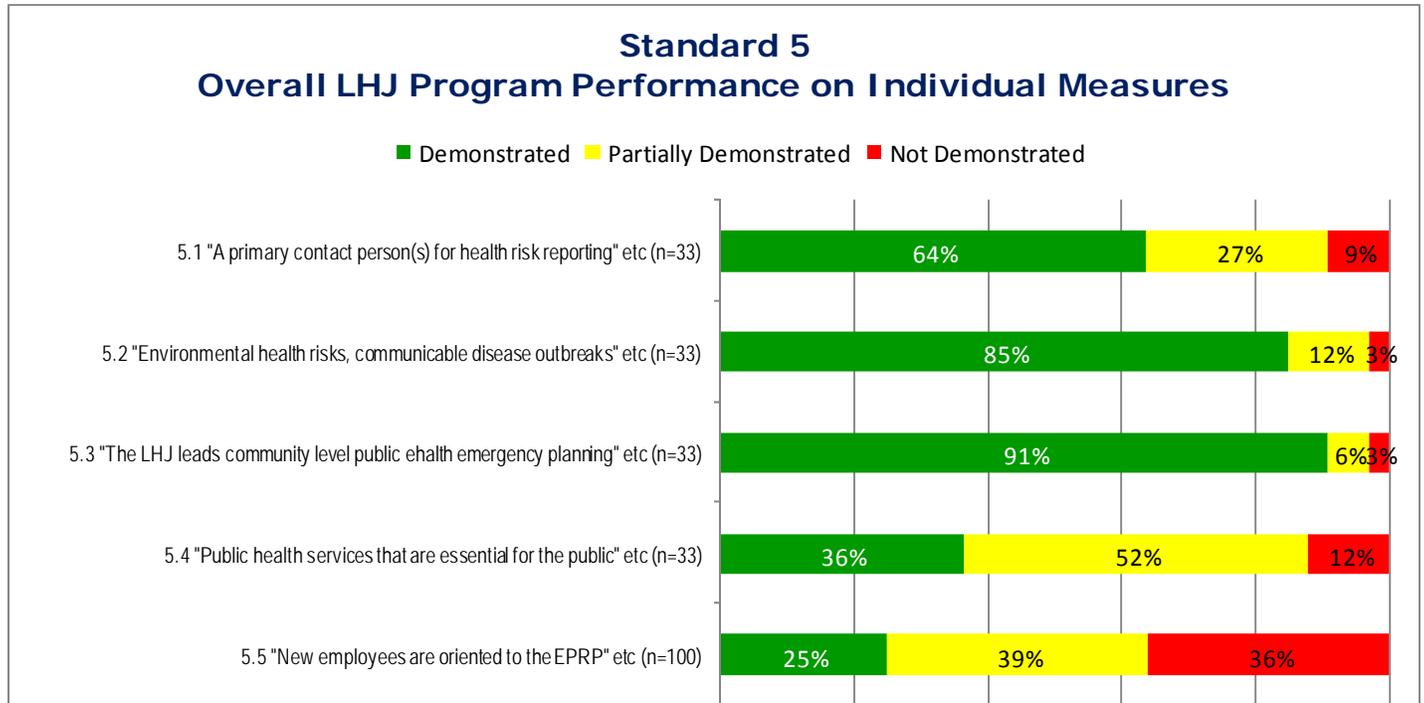
- Measure **4.2L** "Health care providers receive information, through newsletters and other methods, about managing reportable conditions" had 73.5% demonstrated in 2005 and improved to 91.7% demonstrated in 2008.

- Measure **4.5L** *"A notifiable conditions tracking system documents the initial report, investigation, findings and subsequent reporting to state and federal agencies"* had 82.4% demonstrated in 2005 and improved to 100% demonstrated in 2008. This is directly attributable to the successful, statewide implementation of the PHIMS communicable disease database.
- Measure **4.8L** *"A tracking system documents environmental health investigation/compliance activities from the initial report, through investigation, findings, and compliance action, and subsequent reporting to state and federal agencies as required"* had 67% demonstrated in 2005 and improved to 94.1% demonstrated in 2008. This is attributable to the wider use of environmental health tracking databases, such as Envision, in more of the LHJs.

## Standard 5: Planning for and Responding to Public Health Emergencies

Emergency preparedness and response plans and efforts delineate roles and responsibilities in regard to preparation, response, and restoration activities as well as services available in the event of communicable disease outbreaks, environmental health risks, natural disasters and other events that threaten the health of people.

Chart 8

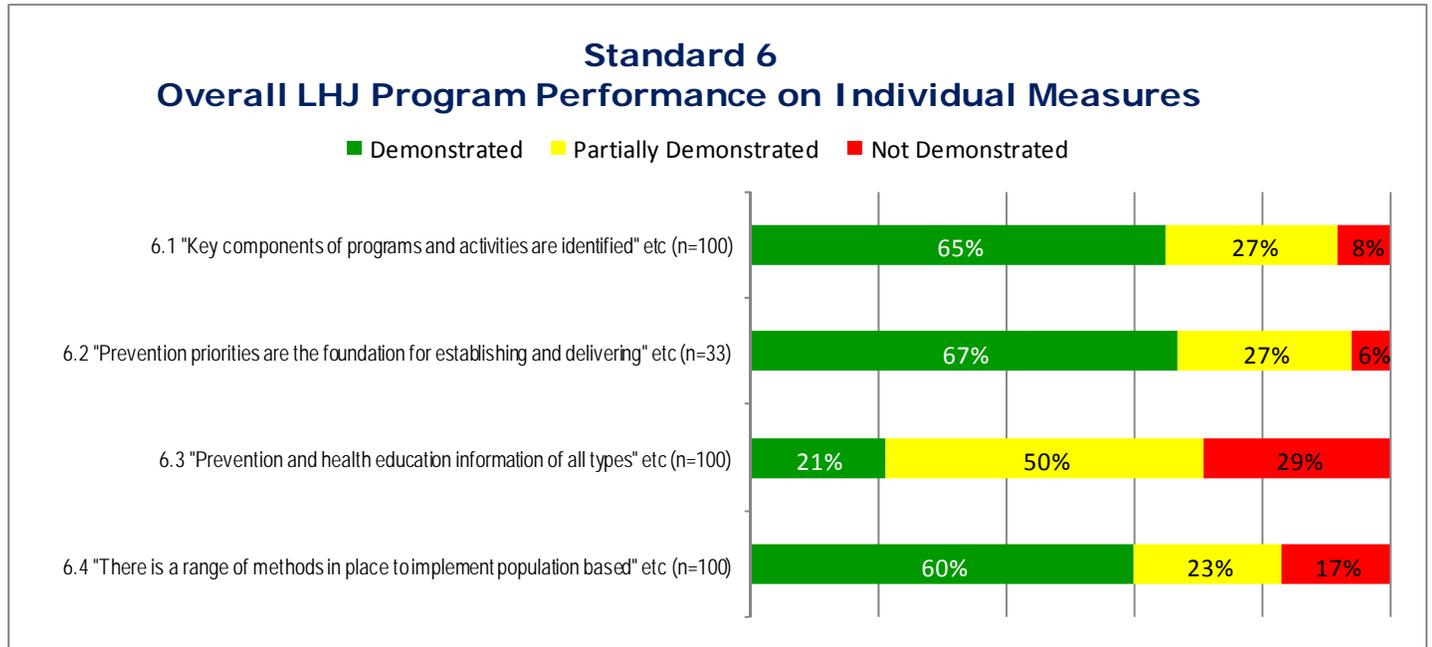


This standard has an aggregate percent demonstrated of 50% which is mid-range performance of a standard for LHJs in 2008. Only three of the five measures in this standard have 50% or more of the LHJs that were able to demonstrate performance. Measure **5.5L**, with just 25% demonstrated performance, highlights the low performance of orienting new employees and annual training of all employees to the EPRP. The same measure at the state level also has low performance. Together, these provide an excellent opportunity to improve EPRP training at both the local and state level.

## Standard 6: Prevention and Education

Prevention and education is a planned component of all public health programs and activities. Examples include wellness/healthy behaviors promotion, healthy child and family development, as well as primary, secondary and tertiary prevention of chronic disease/disability, communicable disease (food/water/air/waste/vector borne) and injuries. Prevention, health promotion, health education, early intervention and outreach services are provided.

Chart 9

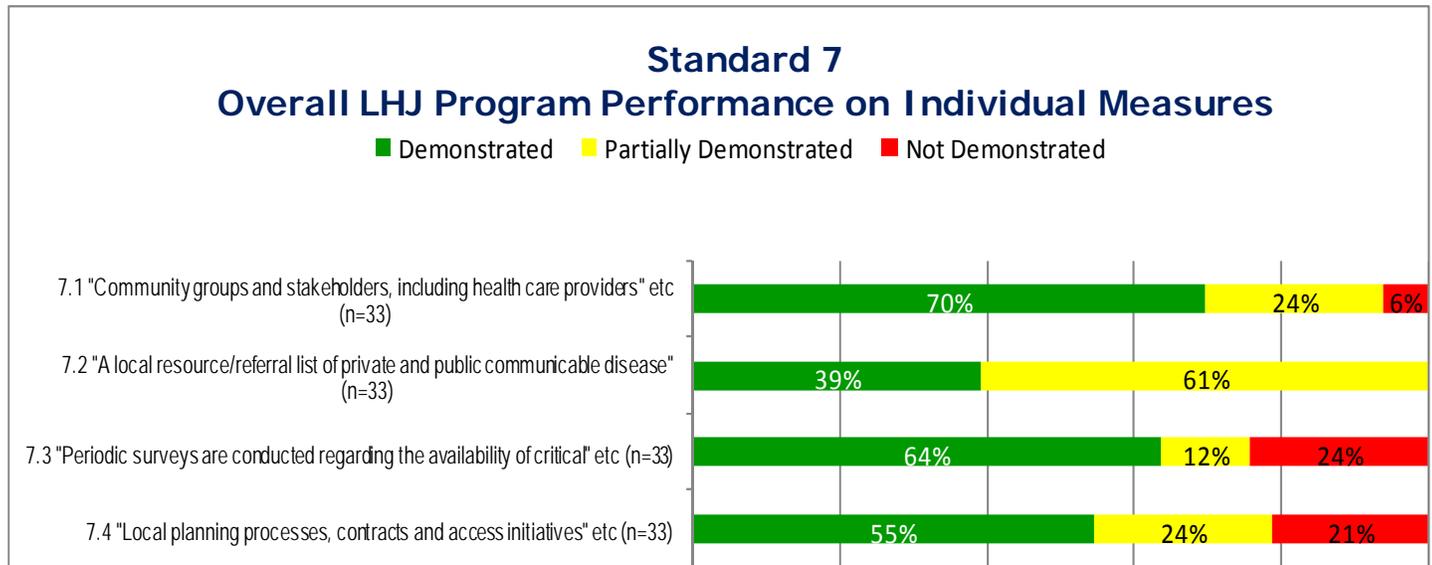


This standard has an aggregate percent demonstrated of 50% which is mid-range performance of a standard for LHJs in 2008. Three of the four measures in this standard have 50% or more of the LHJs that were able to demonstrate performance. Measure **6.3L**, with just 21% demonstrated performance, highlights the need to improve the processes for reviewing and updating prevention and health education information.

## Standard 7: Helping Communities Address Gaps in Critical Health Services

Public health organizations convene, facilitate and provide support for state and local partnerships intended to reduce health disparities and specific gaps in access to critical health services. Analysis of state and local health data is a central role for public health in this partnership process.

Chart 10

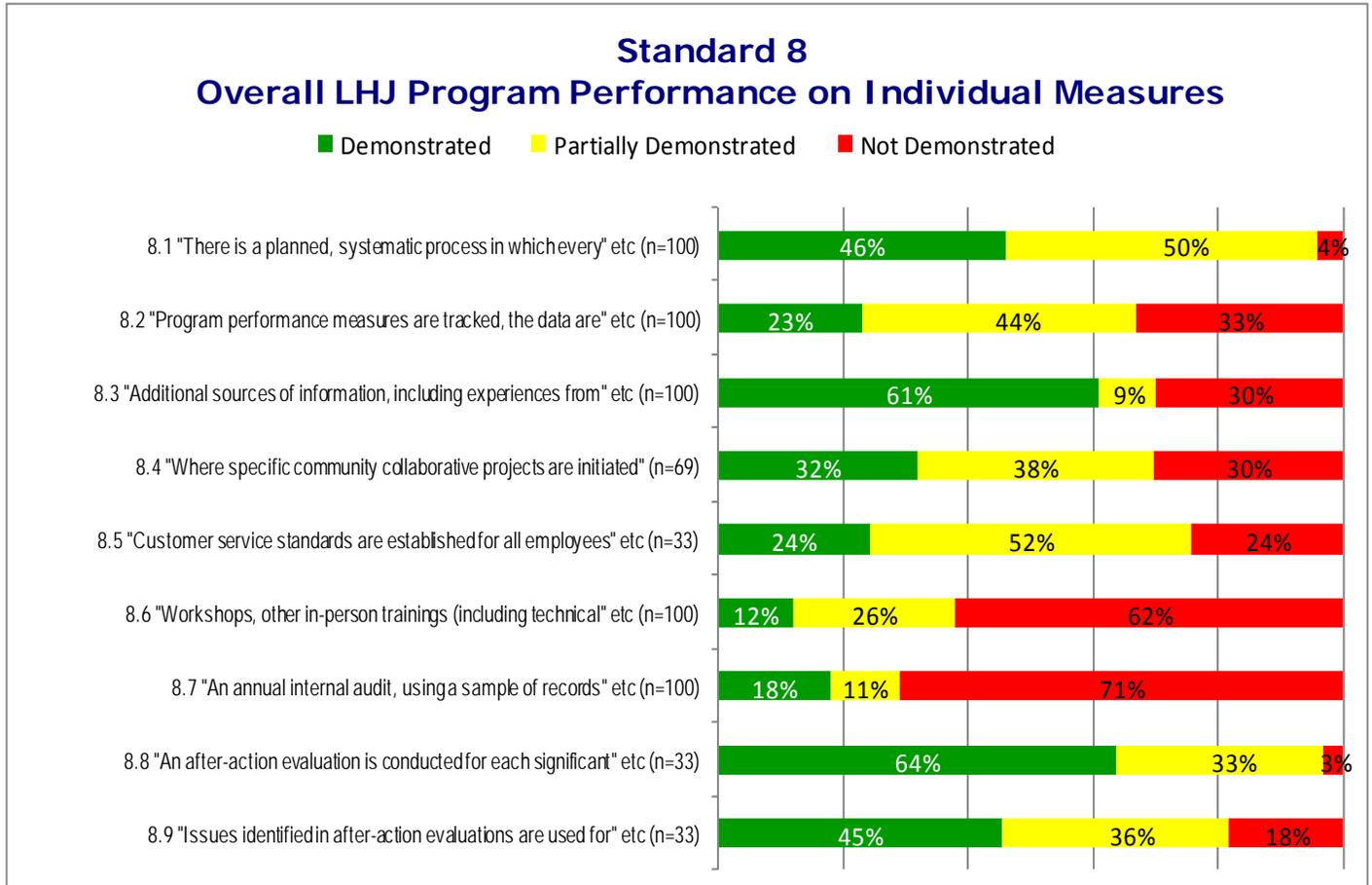


This standard has an aggregate percent demonstrated of 57% which is mid-range performance of a standard for LHJs in 2008. Three of the four measures in this standard have 50% or more of the LHJs that were able to demonstrate performance.

## Standard 8: Program Planning and Evaluation

Public health programs and activities identify specific goals, objectives and performance measures and establish mechanisms for regular tracking, reporting, and use of results.

Chart 11



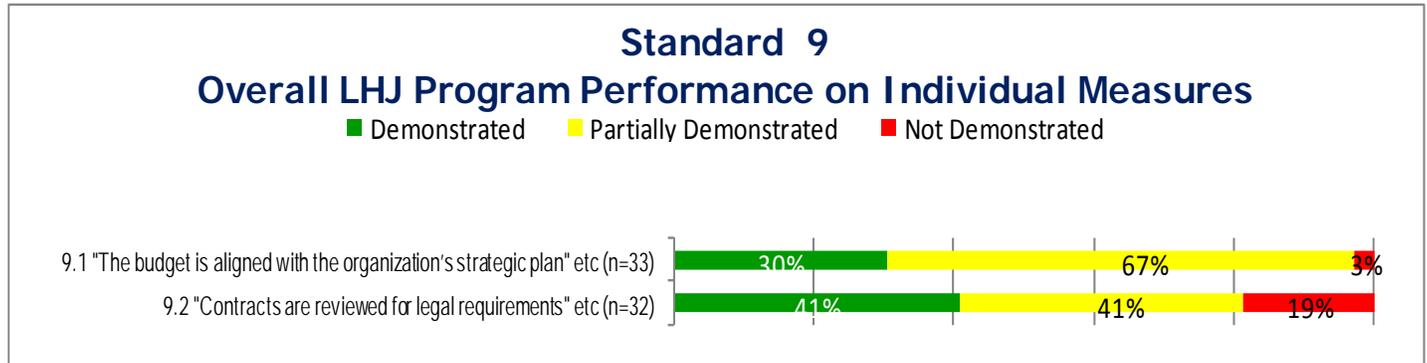
This standard has an aggregate percent demonstrated of 34% which is tied with Standard 12 for the lowest performance in a standard for LHJs in 2008. Only two of the nine measures (18%) in this standard have 50% or more of the LHJs or of local programs able to demonstrate performance. The 50% partially demonstrates result in measure **8.1L** does not reflect that half the LHJs partially demonstrate the establishment of performance measures, but primarily reflects the programs that demonstrated the second requirement in the measure related to the professional requirements for program staff that was scored by reviewing example job descriptions.

**THE FOLLOWING FOUR STANDARDS WERE REVIEWED FOR THE FIRST TIME IN 2008 AND THE RESULTS ARE THE BASELINE FOR PERFORMANCE IN THESE MEASURES.**

**Standard 9: Financial and Management Systems**

Effective financial and management systems are in place in all public health organizations.

Chart 12

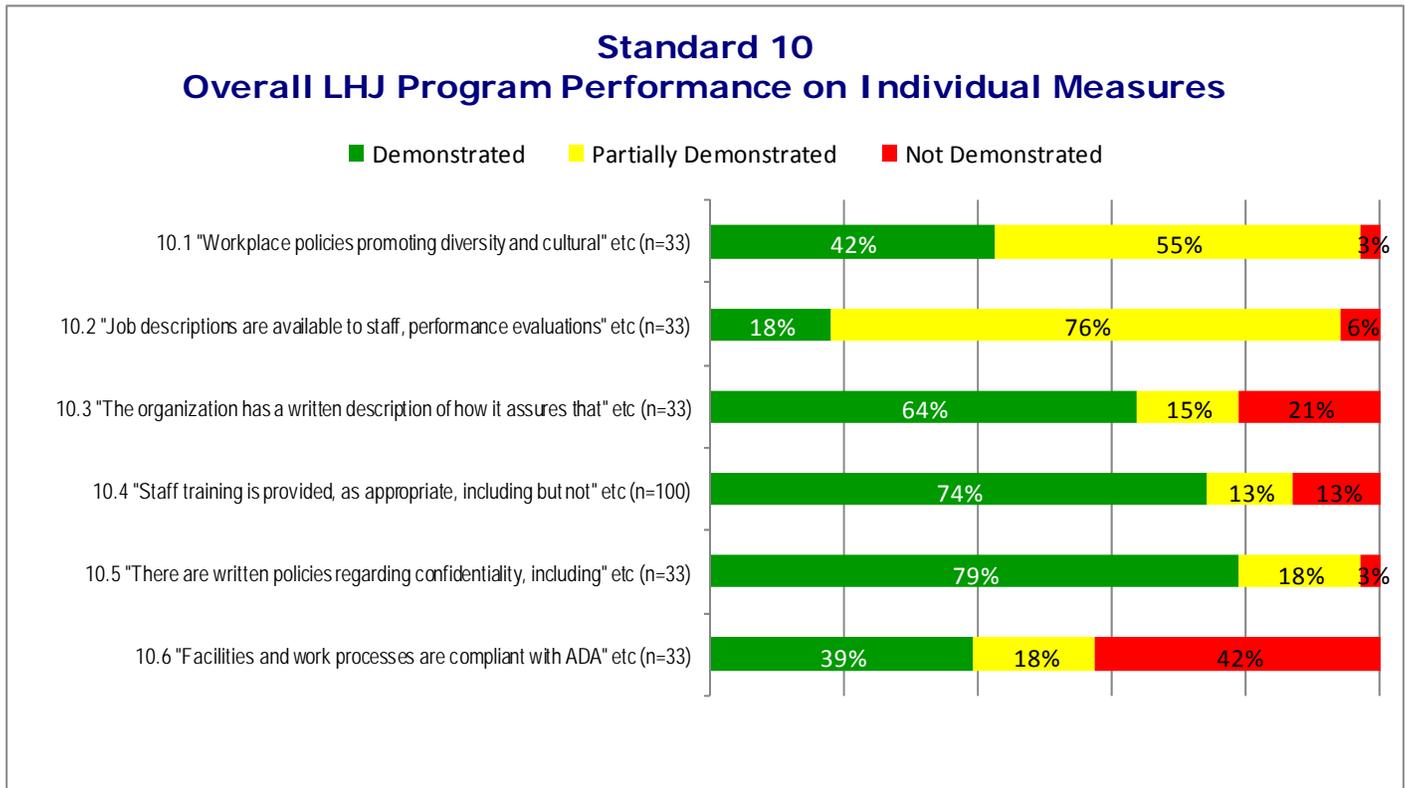


This standard has an aggregate percent demonstrated of 35% which is the third lowest performance of a standard for LHJs in 2008. Neither of the two measures in this standard has 50% or more of the LHJs that were able to demonstrate performance. Measure **9.1L** evaluates the alignment between the agency budget and the agency strategic plan. The low result is partially related to the low percent (24%) of LHJs that have strategic plans, as shown in measure **12.6L**. The lower performance in measure **9.2L** is related to the wide variation in demonstrating that the agency monitors its external contracts with vendors for compliance with requirements.

## Standard 10: Human Resource Systems

Human resource systems and services support the public health workforce.

Chart 13

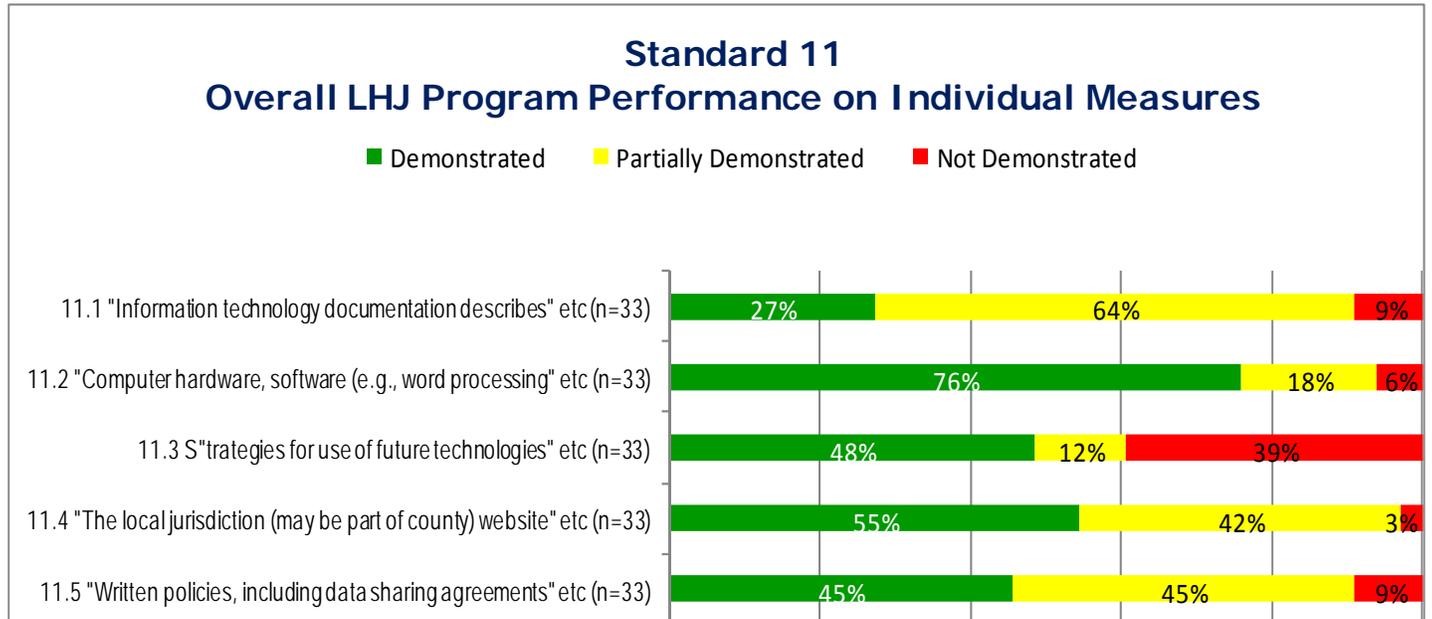


This standard has an aggregate percent demonstrated of 58% which is mid-range performance of a standard for LHJs in 2008. Half of the six measures in this standard have 50% or more of the LHJs that were able to demonstrate performance. The lower performance in measure **10.2L** is related to a relatively low percent of individual staff performance evaluations that are timely and that contain training plans.

## Standard 11: Information Systems

Information systems support the public health mission and staff by providing infrastructure for data collection, analysis, and rapid communication.

Chart 14

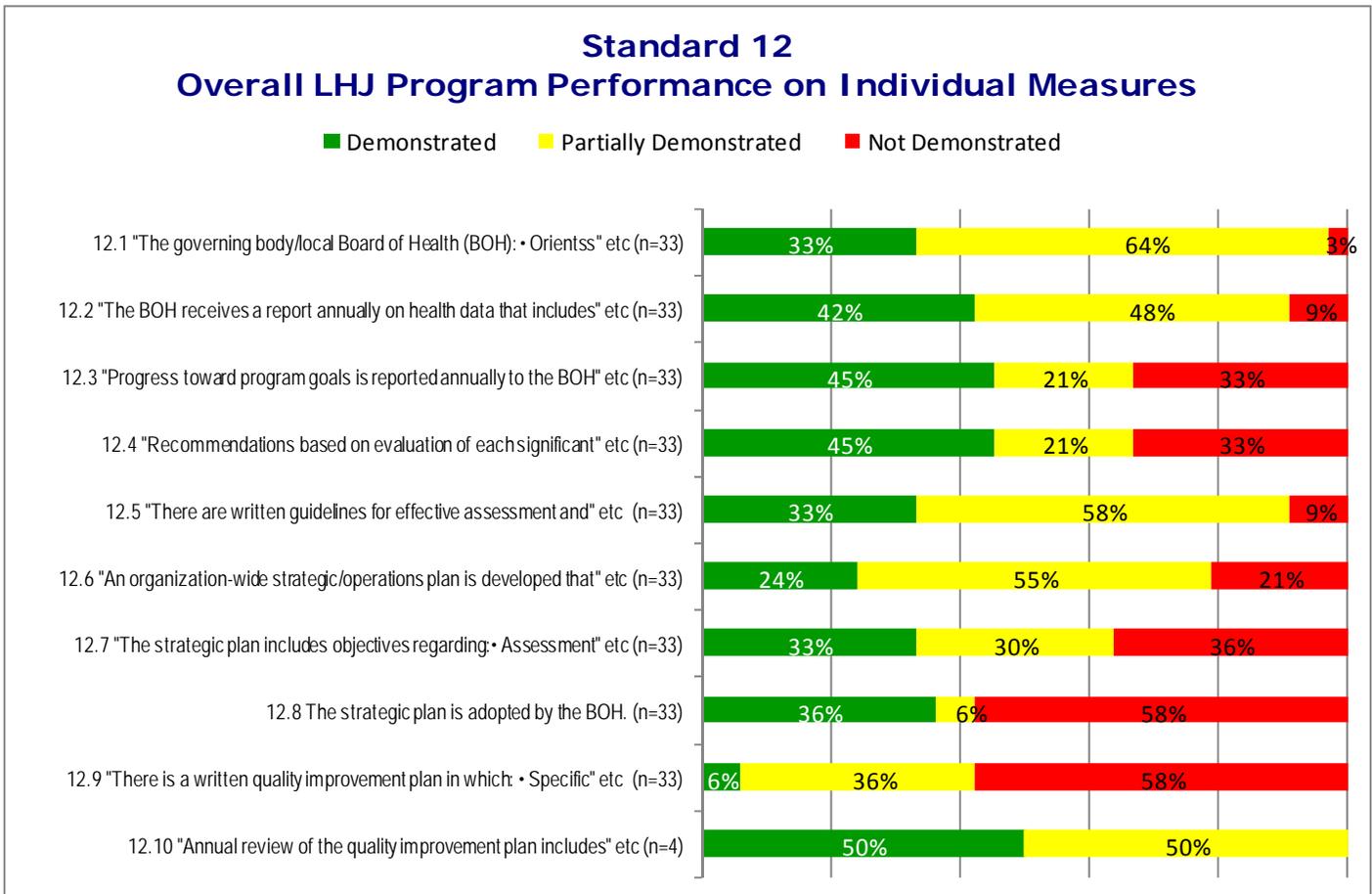


This standard has an aggregate percent demonstrated of 50% which is mid-range performance of a standard for LHJs in 2008. Only two of the five measures (40%) in this standard have 50% or more of the LHJs that were able to demonstrate performance. The lower performance in measure **11.1L** is related to low percent of LHJs (or the county agencies providing the information systems) that demonstrated they were monitoring the security and back-up systems for their databases. The structure of measure **11.5L** makes it difficult to document the sharing and transfer of data in a confidential manner. This measure requires clarification in the next revision of the measures.

## Standard 12: Leadership and Governance

Leadership and governance bodies set organizational policies and direction and assure accountability.

Chart 15



This standard has an aggregate percent demonstrated of 34% which is tied for the lowest performance of a standard for LHJs in 2008. Measures **12.1L** through **12.4L** and **12.8L** are related to local board of health operations and the extent of policy and data review and decision making done by that body. Measures **12.6L** and **12.7L** are related to strategic planning in the local agency. The low result for measure 12.9 is related to the small number of LHJs that have implemented a quality improvement plan for the agency. For measure **12.10L**, only those LHJs that had a quality improvement plan in place were evaluated for annual updating of the plan and for demonstrating at least one improvement.



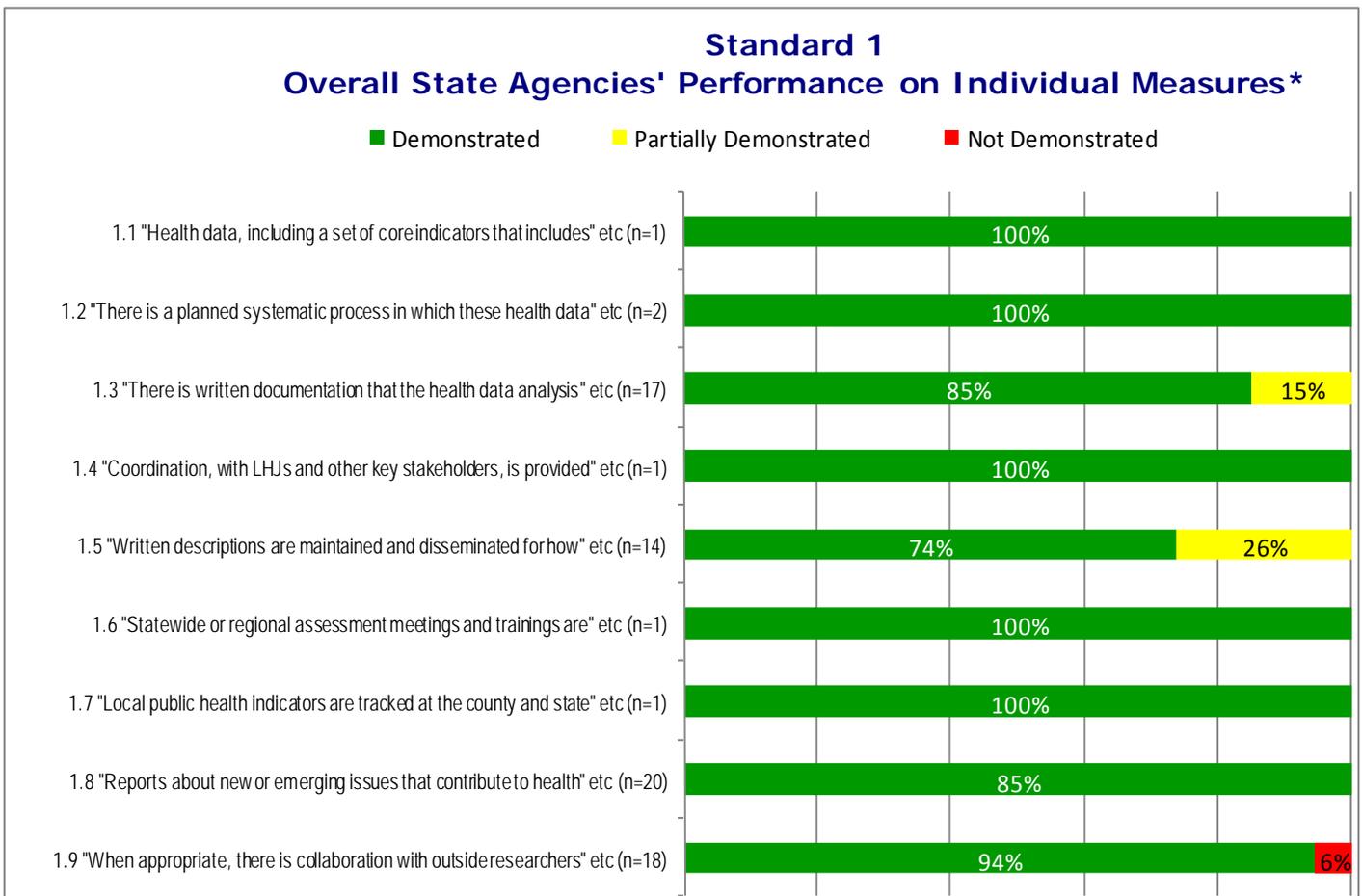
# Appendix B: State (BOH and DOH) Results

## AGGREGATE ANALYSIS

### Standard 1: Community Health Assessment

Data about community health, environmental health risks, health disparities and access to critical health services are collected, tracked, analyzed and utilized along with review of evidence-based practices to support health policy and program decisions.

Chart 16



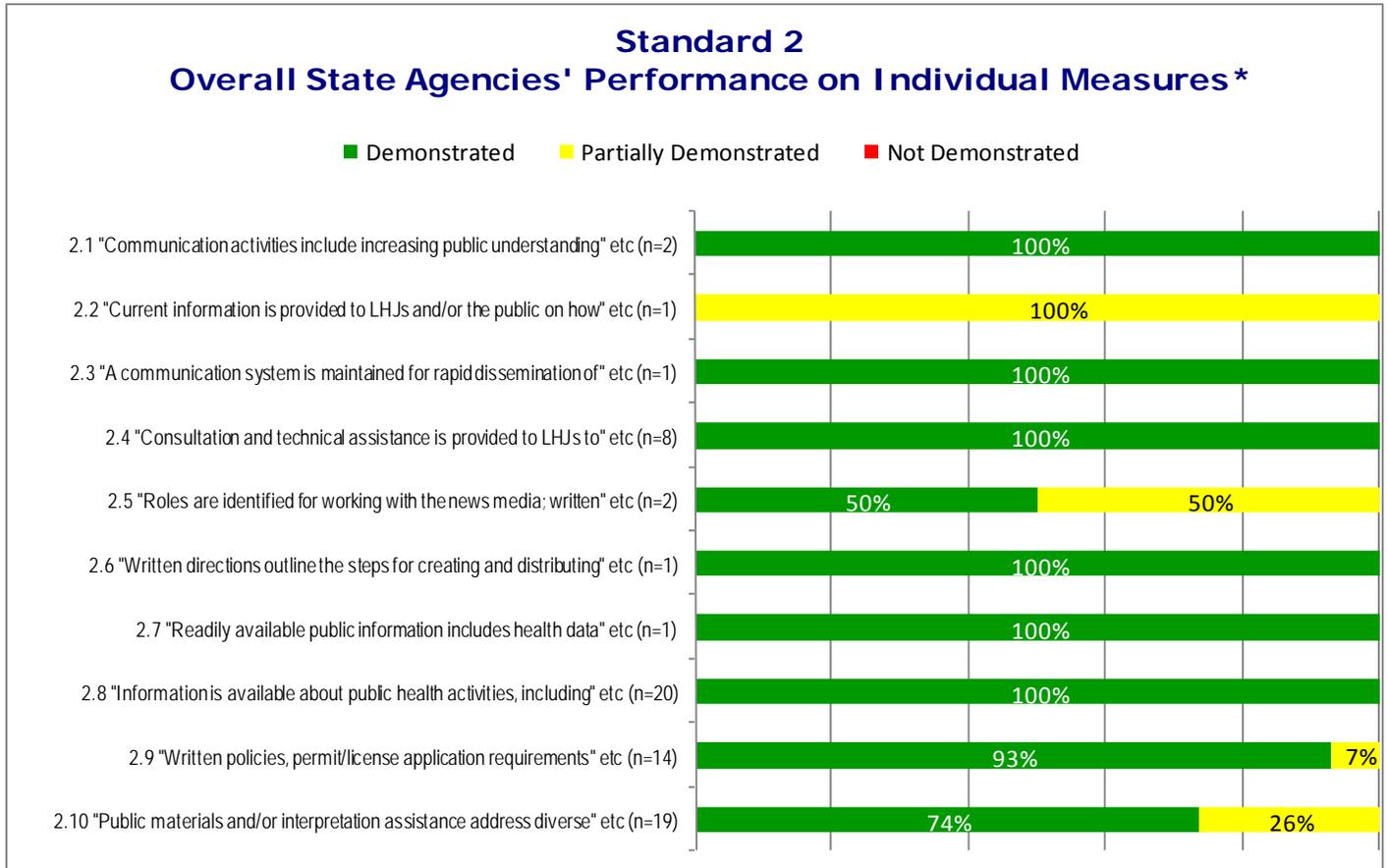
This standard has an aggregate percent demonstrated of 86% which is second highest performance of a standard for DOH in 2008. Most of these measures (**1.1S**, **1.2S**, **1.4S**, **1.6S**, **1.7S**, and **1.8S**) are reviewed just once at the agency level for DOH. This means that there is only one score and the 100% demonstrated is for the agency as a whole. For the other three measures (**1.3S**, **1.5S**, and **1.9S**), all the selected DOH programs were reviewed and scored.

\* Includes State Board of Health

## Standard 2: Communication to the Public and Key Stakeholders

Public information is a planned component of all public health programs and activities. Urgent public health messages are communicated quickly and clearly.

Chart 17



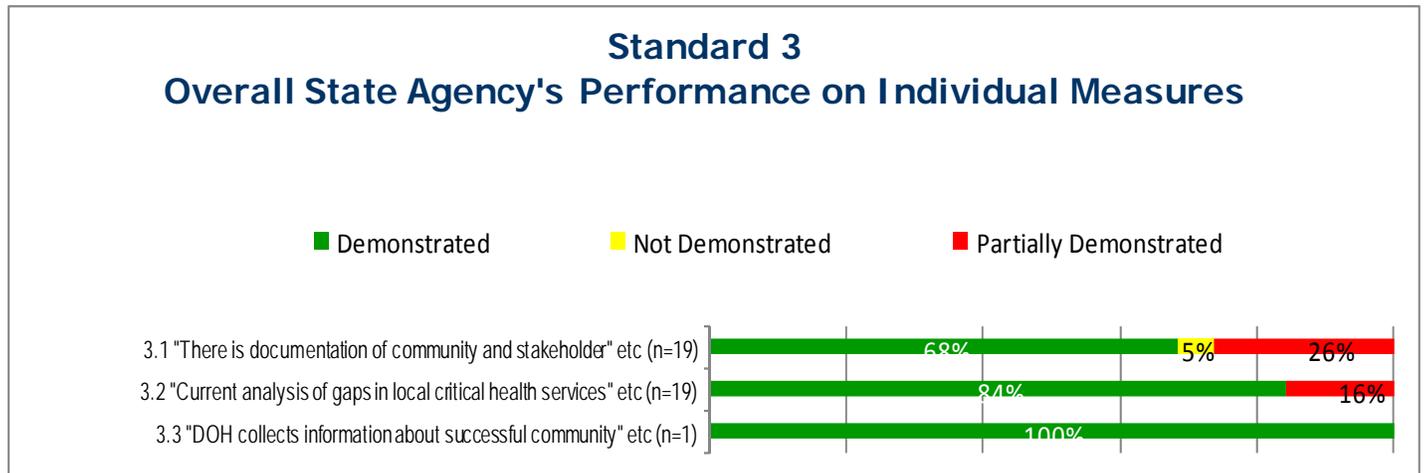
This standard has an aggregate percent demonstrated of 88% which is the highest performance of a standard for DOH in 2008. Most of these measures (**2.1S**, **2.2S**, **2.3S**, **2.4S**, **2.5S**, **2.6S**, and **2.7S**) are reviewed just once at the agency level for DOH. This means that there is only one score and the demonstrated or partially demonstrated score is for the agency as a whole. For the other three measures (**2.8S**, **2.9S**, and **2.10S**), all the selected DOH programs were reviewed and scored.

\* Includes State Board of Health

### Standard 3: Community Involvement

Active involvement of community members and development of collaborative partnerships address community health risks and issues, prevention priorities, health disparities and gaps in healthcare resources/critical health services.

Chart 18

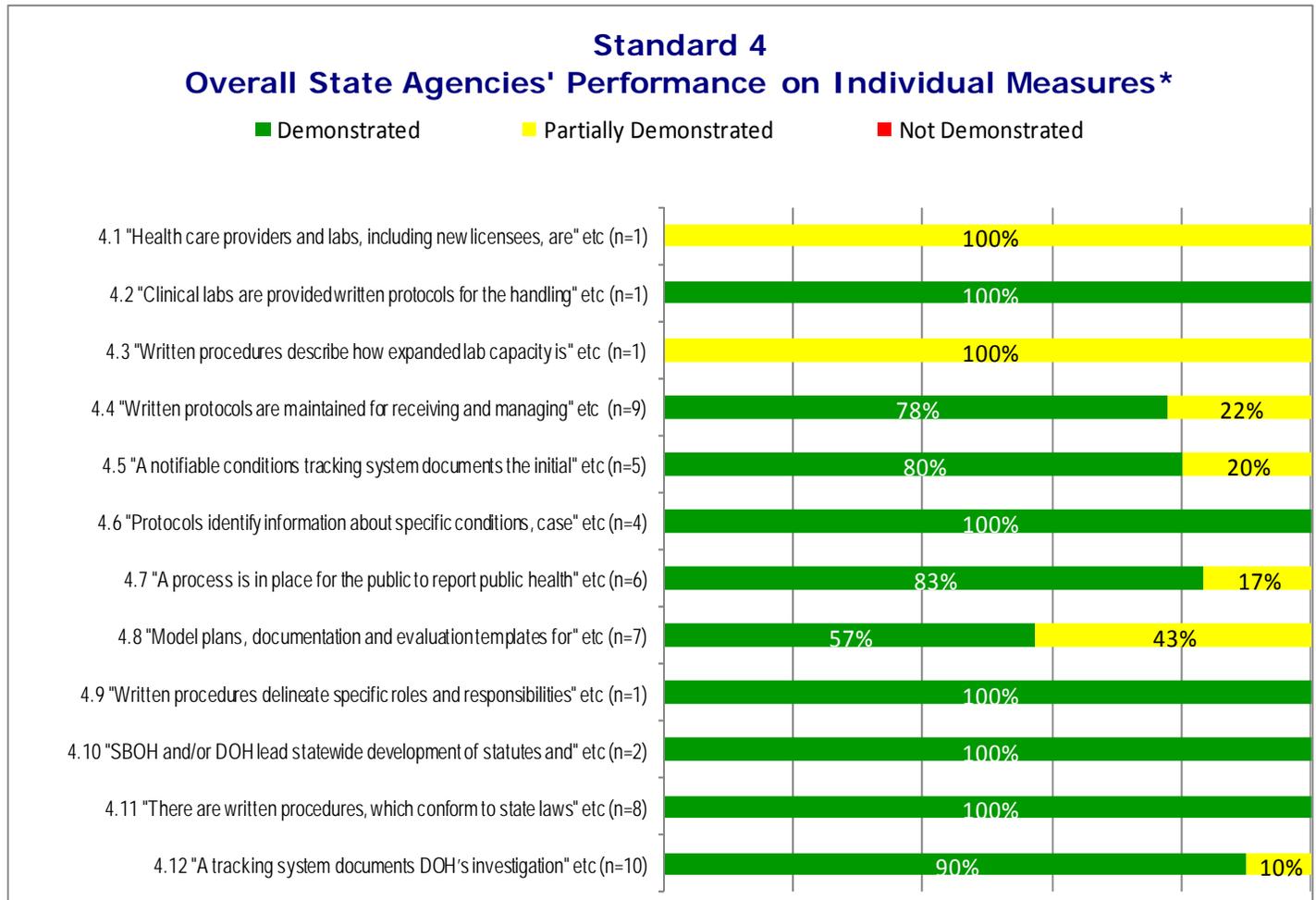


This standard has an aggregate percent demonstrated of 77% which is mid-range performance of a standard for DOH in 2008. The first two measures (**3.1S** and **3.2S**) are applicable to all the DOH programs. Measure **3.3S** was reviewed just once at the agency level for DOH. This means that the demonstrated score is for the agency as a whole.

## Standard 4: Monitoring and Reporting Threats to the Public's Health

A monitoring and reporting process is maintained to identify emerging threats to the public's health. Investigation and control procedures are in place and actions documented. Compliance with regulations is sought through education, information, investigation, permit/license conditions and appropriate enforcement actions.

Chart 19



This standard has an aggregate percent demonstrated of 80% which is the third highest performance of a standard for DOH in 2008. This standard is related to communicable disease activities, environmental health investigations, and other related activities. Two measures (**4.9S** and **4.10S**) are applicable to the agency and were reviewed just once at the agency level for DOH. Several other measures apply to just one or two programs (**4.2S** and **4.3S**) and were reviewed at just one site. Seven of the eight remaining measures that were reviewed in selected programs have more than 50% of the applicable DOH programs that were able to demonstrate performance. None of the five programs reviewed for measure **4.1S** was able to fully demonstrate the measure. Measure **4.1S** is related to providing health care providers and new licensees with information on notifiable conditions reporting. This is an area of low performance at the local level and an opportunity for improvement across the statewide public health system.

### Statistically Significant Improvement

One of the measures in this standard is comparable to a 2005 measure and shows statistically significant improvement:

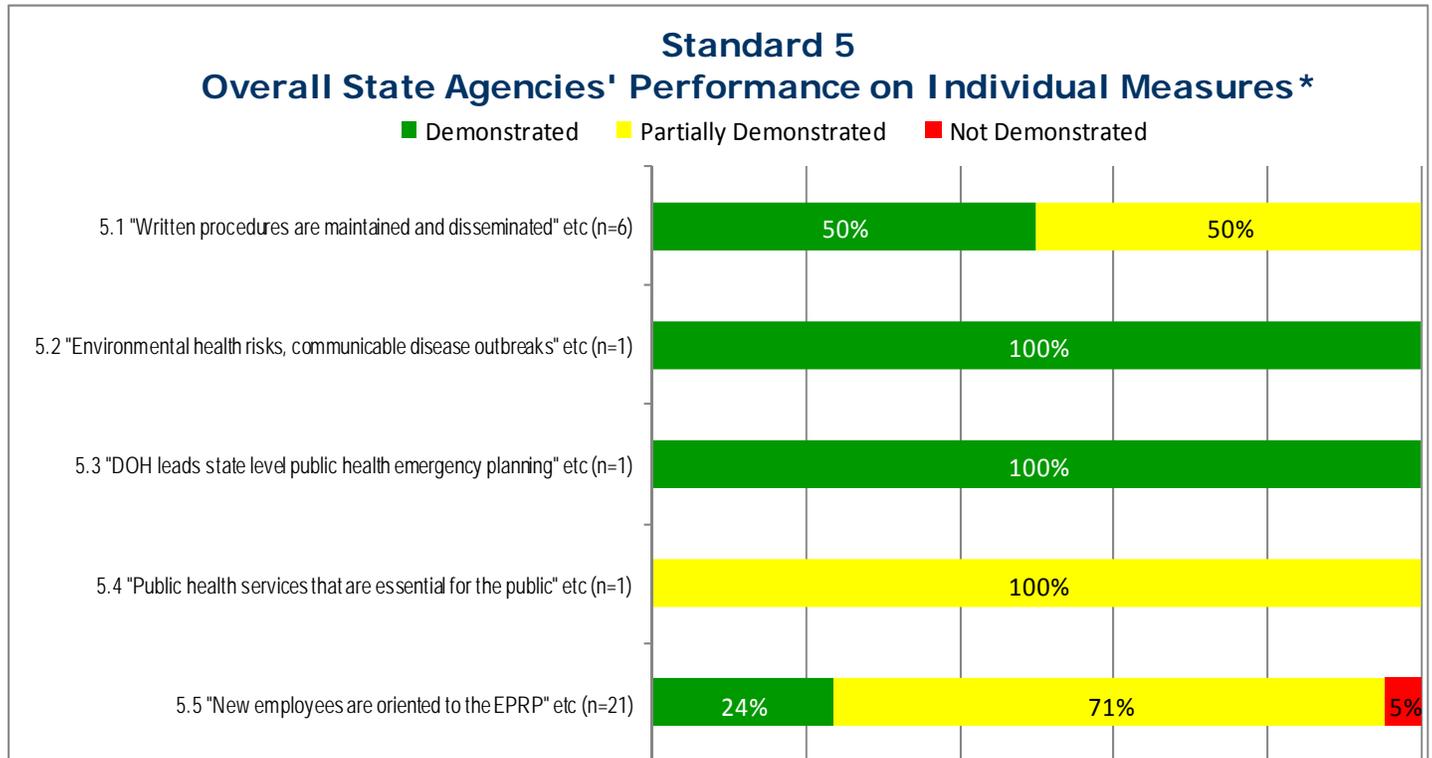
- Measure **4.12S** "A tracking system documents DOH's investigation/compliance activities from the initial report through investigation, findings and compliance actions, and subsequent reporting to state and federal agencies as required" had 33% demonstrated in 2005 and improved to 90% demonstrated in 2008.

\* Includes State Board of Health

## Standard 5: Planning for and Responding to Public Health Emergencies

Emergency preparedness and response plans and efforts delineate roles and responsibilities in regard to preparation, response, and restoration activities as well as services available in the event of communicable disease outbreaks, environmental health risks, natural disasters and other events that threaten the health of people.

Chart 20



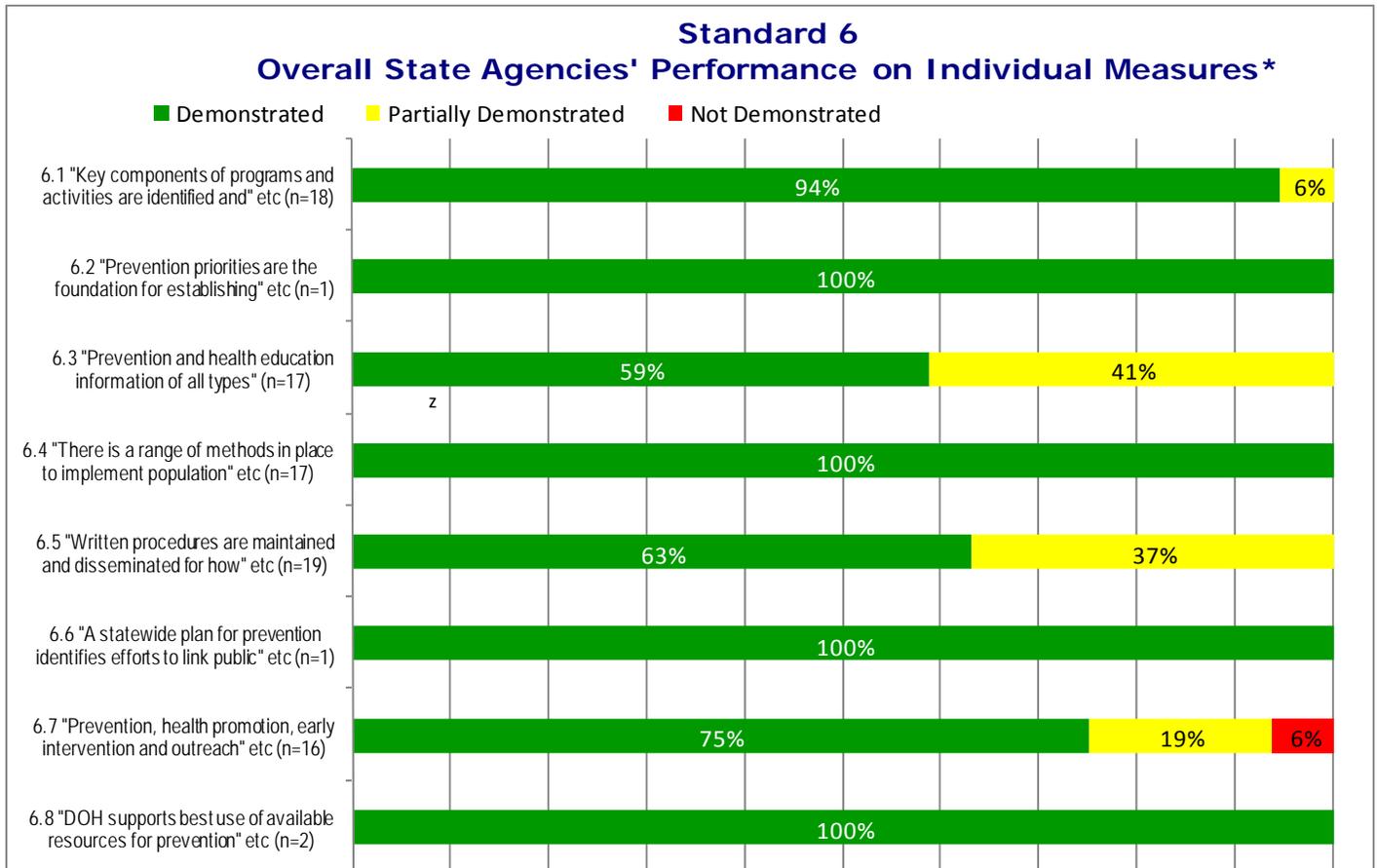
This standard has an aggregate percent demonstrated of 33% which is the lowest performance of a standard for DOH in 2008. Three measures (**5.2S**, **5.3S**, and **5.4S**) are applicable to the state agencies and were reviewed just once at the agency level. Measure **5.5S**, with just 24% demonstrated performance, highlights the low performance of orienting new employees and annual training of all employees to the EPRP. The same measure at the local level also has low performance. Together, these provide an excellent opportunity to improve EPRP training at both the local and state level.

\* Includes State Board of Health

## Standard 6: Prevention and Education

Prevention and education is a planned component of all public health programs and activities. Examples include wellness/healthy behaviors promotion, healthy child and family development, as well as primary, secondary and tertiary prevention of chronic disease/disability, communicable disease (food/water/air/waste/vector borne) and injuries. Prevention, health promotion, health education, early intervention and outreach services are provided.

Chart 21



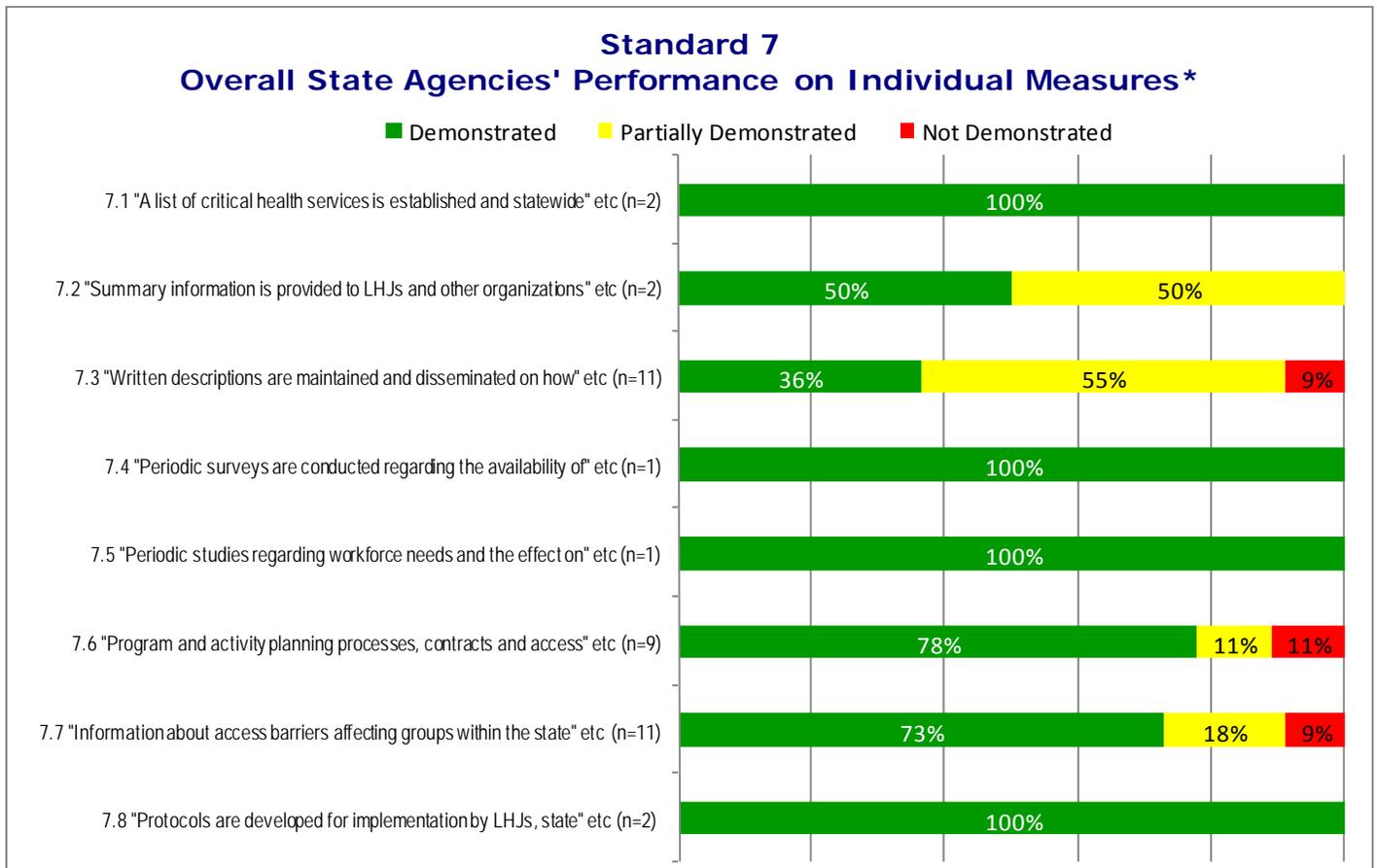
This standard has an aggregate percent demonstrated of 79% which is the fourth highest performance of a standard for DOH in 2008. Three measures (**6.2S**, **6.6S**, and **6.8S**) are applicable to the state agencies and were reviewed just once at the agency level.

\* Includes State Board of Health

## Standard 7: Helping Communities Address Gaps in Critical Health Services

Public health organizations convene, facilitate and provide support for state and local partnerships intended to reduce health disparities and specific gaps in access to critical health services. Analysis of state and local health data is a central role for public health in this partnership process.

Chart 22



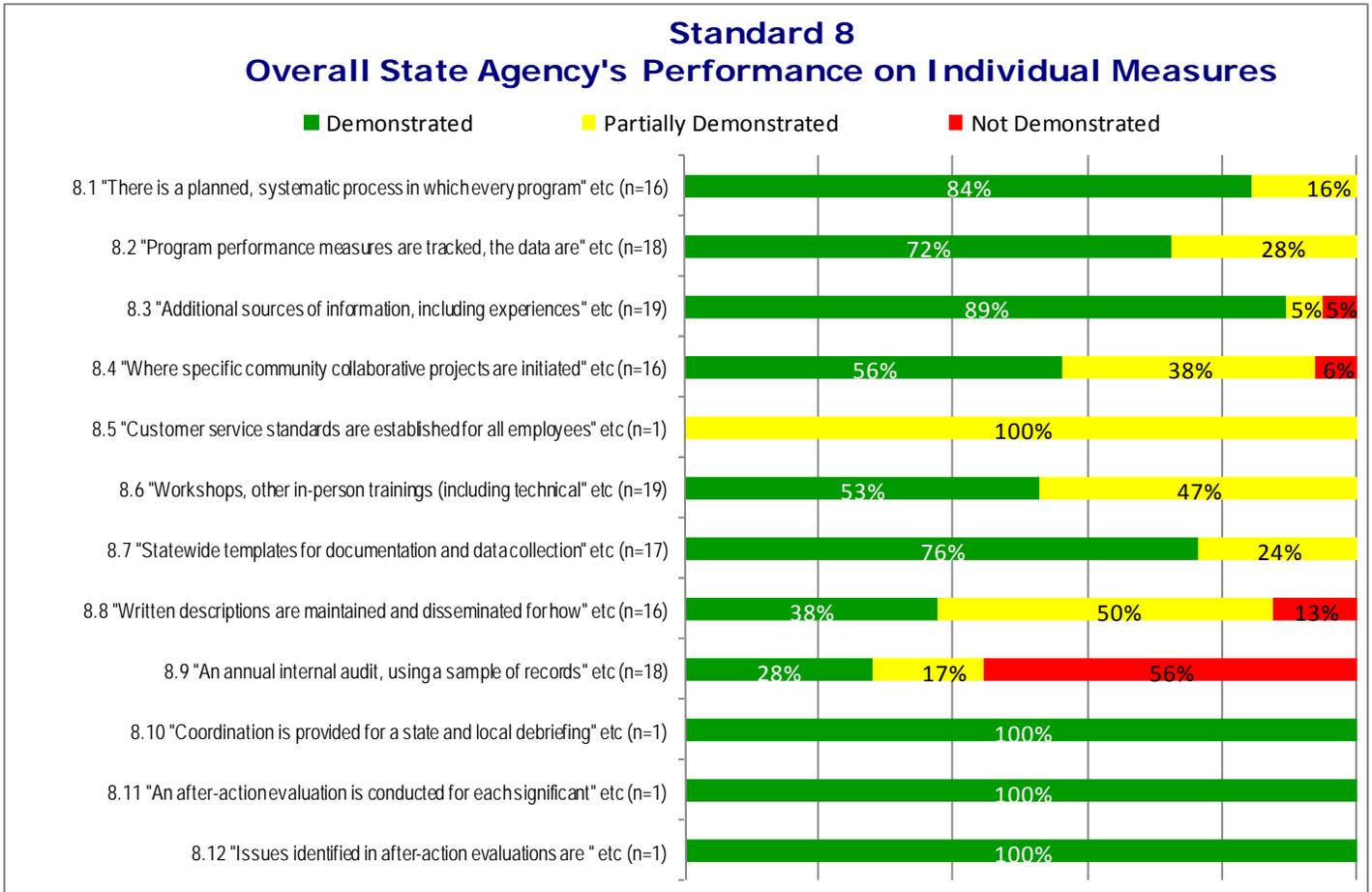
This standard has an aggregate percent demonstrated of 67% which is mid-range performance of a standard for DOH in 2008. Measure **7.1S** is applicable at the agency level and measure **7.5S** is applicable to one program, so these two measures were reviewed just once. Measure **7.3S**, with only 36% demonstrated performance, evaluates the processes for providing technical assistance and consultation to LHJs and other stakeholders. This is an area needing improvement across numerous measures for DOH.

\* Includes State Board of Health

## Standard 8: Program Planning and Evaluation

Public health programs and activities identify specific goals, objectives and performance measures and establish mechanisms for regular tracking, reporting, and use of results.

Chart 23



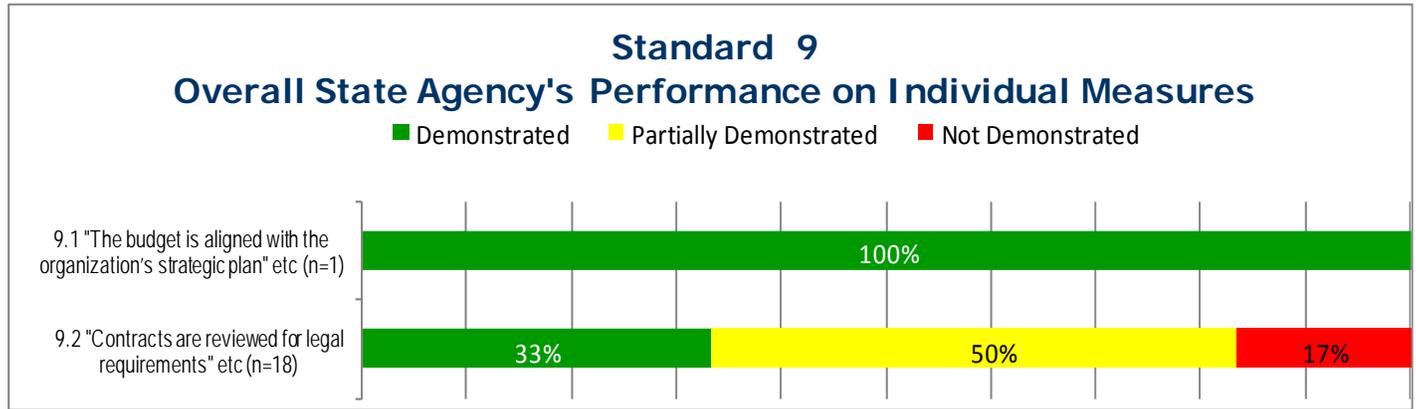
This standard has an aggregate percent demonstrated of 63% which is mid-range performance of a standard for DOH in 2008. The high performance result of 84% in measure **8.1S** reflects the agency-wide initiative DOH conducted to have programs develop logic models and establish performance measures in all programs. Measure **8.8S**, related to technical assistance/consultation, has only 38% demonstrated performance. Four of the measures are agency-level measures (**8.5S**, **8.10S**, **8.11S**, and **8.12S**) and were reviewed just once.

**THE FOLLOWING FOUR STANDARDS WERE REVIEWED FOR THE FIRST TIME IN 2008 AND THE RESULTS ARE THE BASELINE FOR PERFORMANCE IN THESE MEASURES.**

**Standard 9: Financial and Management Systems**

Effective financial and management systems are in place in all public health organizations.

Chart 24

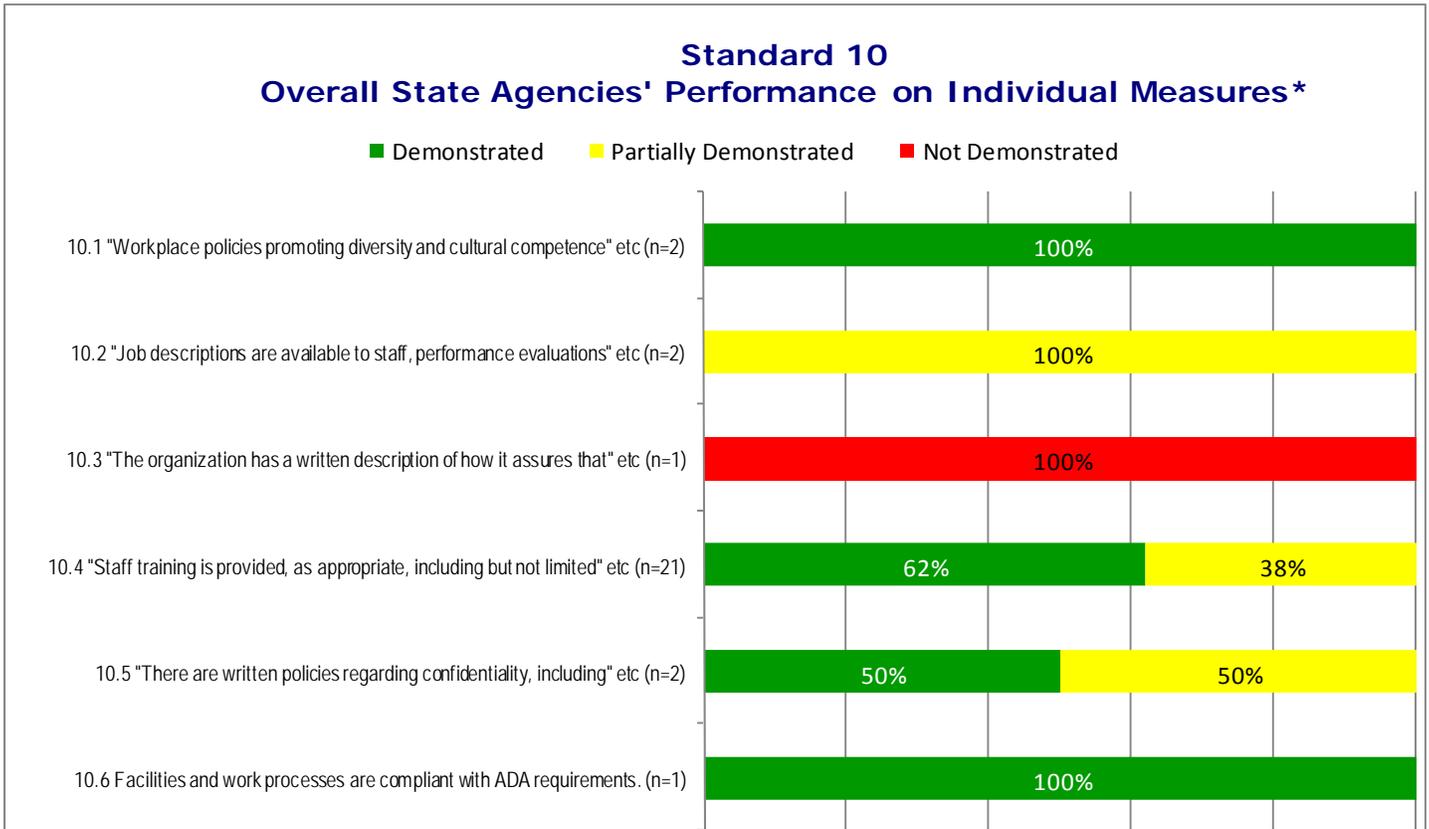


This standard has an aggregate percent demonstrated of 37% which is the second lowest performance of a standard for DOH in 2008. Measure **9.1S** evaluates the alignment between the budget and the strategic plan at the agency level and was reviewed just once. The lower performance in measure **9.2S** is related to the wide variation in demonstrating that DOH programs monitor their external contracts with vendors for compliance with requirements.

**Standard 10: Human Resource Systems**

Human resource systems and services support the public health workforce.

Chart 25



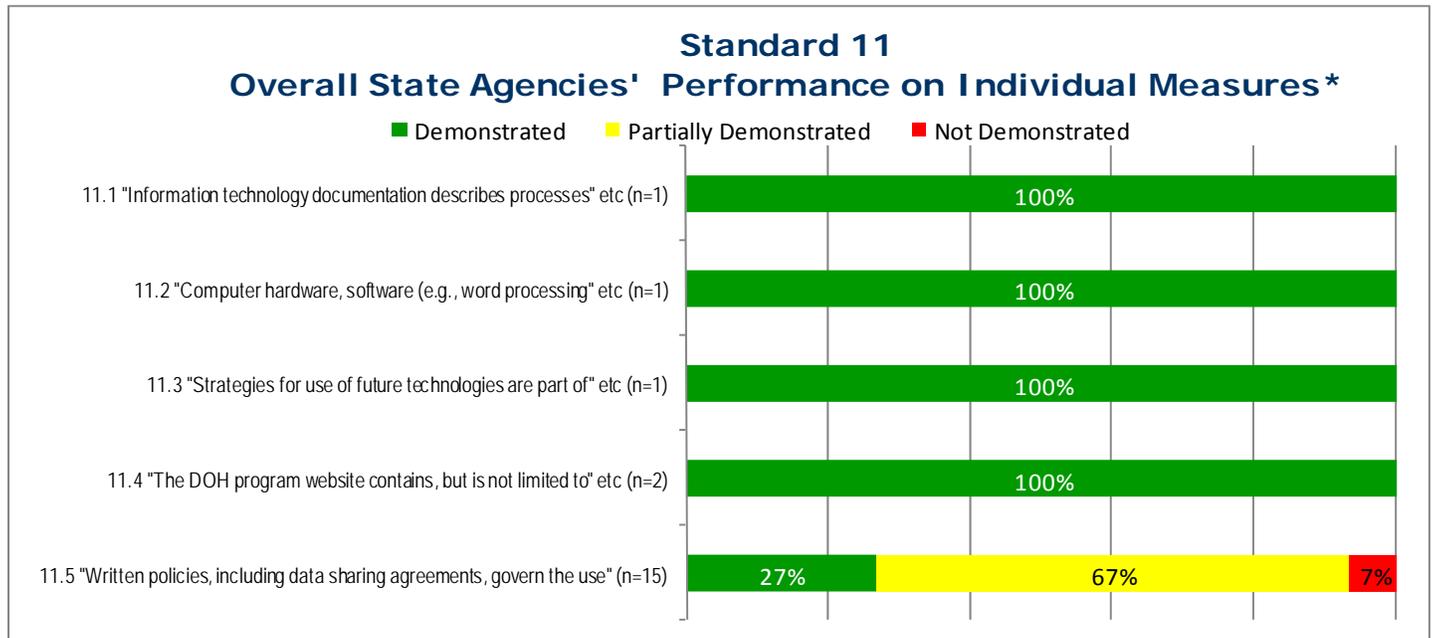
This standard has an aggregate percent demonstrated of 59% which is mid-range performance of a standard for DOH in 2008. Only measure **10.4S** was reviewed for all programs. The rest of the measures were evaluated once for the agency. The partial performance in measure **10.2S** is related to a relatively low percent of individual staff performance evaluations that are timely and that contain training plans.

\* Includes State Board of Health

## Standard 11: Information Systems

Information systems support the public health mission and staff by providing infrastructure for data collection, analysis, and rapid communication.

Chart 26



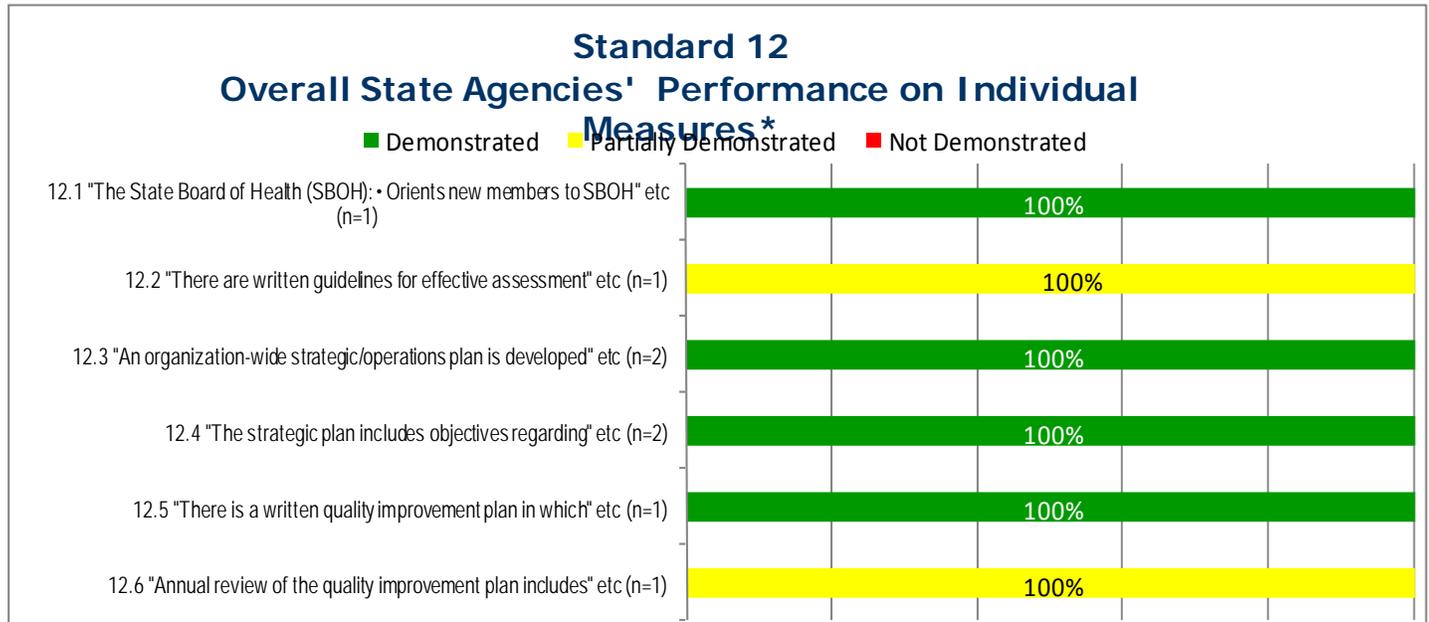
This standard has an aggregate percent demonstrated of 45% which is the third lowest performance of a standard for DOH in 2008. Measures **11.1S** through **11.4S** were evaluated once for the agency. Only measure **11.5S** was reviewed for all programs. The structure of measure **11.5S** makes it difficult to document the sharing and transfer of data in a confidential manner. This measure requires clarification in the next revision of the measures.

\* Includes State Board of Health

**Standard 12: Leadership and Governance**

Leadership and governance bodies set organizational policies and direction and assure accountability.

Chart 27



This standard has an aggregate percent demonstrated of 75% which is mid-range performance of a standard for DOH in 2008. All of the measures are agency measures and were evaluated once for the agency. Measures **12.5S** and **12.6S** are related to implementation of a quality improvement plan for the agency. The partially demonstrated result for measure **12.6S** is related to the annual update of the quality improvement plan and to demonstrating at least one improvement.

\* Includes State Board of Health

## Appendix C:

# Standards and Measures

### STANDARD 1: COMMUNITY HEALTH ASSESSMENT

Data about community health, environmental health risks, health disparities, and access to critical health services are collected, tracked, analyzed, and utilized along with review of evidence-based practices to support health policy and program decisions.

STATE MEASURES		LHJ MEASURES	
<b>1.1S</b>	Health data, including a set of core indicators that includes data about population health status, communicable disease, environmental health risks and related illness, health disparities, and access to critical health services are updated at least every other year and used as the basis for continuous tracking of the health status of the population. Some data sets may have less frequent updates available but should still be included for review as part of an annual health data report. Health data include quantitative data with standard definitions and standardized measures as well as qualitative data.	<b>1.1L</b>	Local health data, including a set of core indicators that includes data about population health status, communicable disease, environmental health risks and related illness, health disparities, and access to critical health services are updated at least every other year and used as the basis for continuous tracking of the health status of the population. Some data sets may have less frequent updates available but should still be included for review as part of an annual health data report. Health data include quantitative data with standard definitions and standardized measures as well as qualitative data.
<b>1.2S</b>	<p>There is a planned, systematic process in which these health data are tracked over time and analyzed, along with review of evidence-based practices, to:</p> <ul style="list-style-type: none"> <li>• Signal changes in health disparities and priority health issues</li> <li>• Identify emerging health issues</li> <li>• Identify implications for changes in communicable disease or environmental health investigation, intervention, or education efforts</li> <li>• Perform gap analyses comparing existing services to projected need for services (these may be state-wide or regional)</li> <li>• Develop recommendations for policy decisions, program changes, or other actions</li> </ul>	<b>1.2L</b>	<p>There is a planned, systematic process in which these health data are tracked over time and analyzed, along with review of evidence-based practices, to:</p> <ul style="list-style-type: none"> <li>• Signal changes in health disparities and priority health issues</li> <li>• Identify emerging health issues</li> <li>• Identify implications for changes in communicable disease or environmental health investigation, intervention, or education efforts</li> <li>• Perform gap analyses comparing existing services to projected need for services</li> <li>• Develop recommendations for policy decisions, program changes, or other actions</li> </ul>

STATE MEASURES	
<b>1.3S</b>	There is written documentation that the health data analysis in <b>1.2S</b> results in the development of recommendations regarding health policy and program development. There is written documentation that shows what health data was used to guide health policy decisions. LHJs are involved in development of state-level recommendations that affect local operations.
<b>1.4S</b>	Coordination with LHJs and other key stakeholders is provided in the development and use of local public health indicators and data standards, including definitions and descriptions.
<b>1.5S</b>	Written descriptions are maintained and disseminated for how to obtain consultation and technical assistance for LHJs or state programs regarding health data collection and analysis; written documentation demonstrates that consultation and technical assistance have been provided.
<b>1.6S</b>	Statewide or regional assessment meetings and trainings are convened to expand available assessment expertise and provide a forum for peer learning and exchange on the practice of community health assessment. Meeting content and attendance is documented.
<b>1.7S</b>	Local public health indicators are tracked at the county and state levels. DOH provides a report to LHJs and other stakeholders at least every other year that contains trend analysis over time.
<b>1.8S</b>	Reports about new or emerging issues that contribute to health policy choices are routinely developed and disseminated. Reports include information about evidence-based practices in addressing health issues.

LHJ MEASURES	
<b>1.3L</b>	There is written documentation that the health data analysis in <b>1.2L</b> results in the development of recommendations regarding health policy and program development. There is written documentation that shows what health data was used to guide health policy decisions.
<b>1.4L</b>	A process is in place to assure that local health data are shared with appropriate local, state, and regional organizations.
<b>1.5L</b>	There is a written description of how and where community members and stakeholders may obtain technical assistance from the LHJ on assessment issues.
<b>1.6L</b>	LHJ staff responsible for assessment activities participate in statewide or regional assessment meetings and trainings to expand available assessment expertise. Attendance is documented.
	No corresponding measure
	No corresponding measure

STATE MEASURES	
<b>1.9S</b>	<p>When appropriate, there is collaboration with outside researchers engaging in research activities that benefit the health of the community including:</p> <ul style="list-style-type: none"> <li>• Identification of appropriate populations, geographic areas, or partners</li> <li>• Active involvement of the LHJ and/or community</li> <li>• Provision of data and expertise to support research</li> <li>• Facilitation of efforts to share research findings with state stakeholders, the community, governing bodies, and policy makers</li> </ul>

LHJ MEASURES	
<b>1.7L</b>	<p>When appropriate, there is collaboration with outside researchers engaging in research activities that benefit the health of the community.</p>

**STANDARD 2: COMMUNICATION TO THE PUBLIC AND KEY STAKEHOLDERS**

Public information is a planned component of all public health programs and activities. Urgent public health messages are communicated quickly and clearly.

STATE MEASURES		LHJ MEASURES	
<b>2.1S</b>	Communication activities include increasing public understanding of the mission and role of public health.	<b>2.1L</b>	Communication activities include increasing public understanding of the mission and role of public health.
<b>2.2S</b>	Current information is provided to LHJs and/or the public on how to contact DOH to report a public health emergency or environmental health risk 24 hours per day. Phone numbers for weekday and after-hours emergency contacts are available to law enforcement and appropriate state agencies. Phone numbers for after-hours contacts for all local and state public health jurisdictions are updated and disseminated statewide at least annually.	<b>2.2L</b>	Current information is provided to the public on how to contact the LHJ to report a public health emergency or environmental health risk 24 hours per day. Phone numbers for weekday and after-hours emergency contacts are available to law enforcement and appropriate local agencies and organizations, such as tribal governments, schools, and hospitals.
<b>2.3S</b>	A communication system is maintained for rapid dissemination of urgent public health messages to the media, LHJs, other state and federal/national agencies, and key stakeholders. State-issued announcements are shared with LHJs in a timely manner.	<b>2.3L</b>	Urgent information is provided through public health alerts to the media and to key stakeholders.
<b>2.4S</b>	Consultation and technical assistance is provided to LHJs to assure the accuracy and clarity of public health information associated with an outbreak, environmental health event, or other public health emergency; written documentation demonstrates that consultation and technical assistance have been provided.		No corresponding measure
	No corresponding measure	<b>2.4L</b>	A current contact list of media and key stakeholders is maintained, updated at least annually, and available to staff as part of the emergency response plan and/or at appropriate departmental locations.

STATE MEASURES		LHJ MEASURES	
<b>2.5S</b>	Roles are identified for working with the news media; written statements identify the timeframes for communications and the expectations for all staff regarding information-sharing and response to questions.	<b>2.5L</b>	Roles are identified for working with the news media; written statements identify the timeframes for communications and the expectations for all staff regarding information-sharing and response to questions.
<b>2.6S</b>	Written directions outline the steps for creating and distributing clear and accurate public health alerts and media releases.	<b>2.6L</b>	Written directions outline the steps for creating and distributing clear and accurate public health alerts and media releases.
<b>2.7S</b>	Readily available public information includes health data, information on environmental health risks, communicable disease, and other threats to the public's health.	<b>2.7L</b>	Readily available public information includes health data, information on environmental health risks, communicable disease and other threats to the public's health as well as information regarding access to the local health system, healthcare providers, and prevention resources.
<b>2.8S</b>	Information is available about public health activities, including educational offerings, and reporting and compliance requirements through brochures, flyers, newsletters, websites, or other mechanisms.	<b>2.8L</b>	Information is available about public health activities, including educational offerings, and reporting and compliance requirements through brochures, flyers, newsletters, websites, or other mechanisms.
<b>2.9S</b>	Written policies, permit/license application requirements, administrative code, and enabling laws are available to the public.	<b>2.9L</b>	Written policies, local ordinances, permit/license application requirements, administrative code, and enabling laws are available to the public.
<b>2.10S</b>	Public materials and/or interpretation assistance address diverse populations, languages, and literacy, as needed.	<b>2.10L</b>	Public materials and/or interpretation assistance address diverse local populations, languages, and literacy, as needed.
	No corresponding measure	<b>2.11L</b>	LHJ staff and contractors have a local resource/referral list of private and public communicable disease treatment providers, providers of critical health services, and providers of preventive services for the staff and community to use in making referrals.

### STANDARD 3: COMMUNITY INVOLVEMENT

Active involvement of community members and development of collaborative partnerships address community health risks and issues, prevention priorities, health disparities, and gaps in healthcare resources/critical health services.

STATE MEASURES		LHJ MEASURES	
<b>3.1S</b>	<p>There is documentation of community and stakeholder involvement in the process of reviewing health data and the set of core indicators and recommending action such as:</p> <ul style="list-style-type: none"> <li>• Further investigation</li> <li>• New program efforts</li> <li>• Policy direction</li> <li>• Prevention priorities</li> </ul>	<b>3.1L</b>	<p>There is documentation of community and stakeholder involvement in the process of reviewing the local health data and the set of core indicators and recommending action such as:</p> <ul style="list-style-type: none"> <li>• Further investigation</li> <li>• New program efforts</li> <li>• Policy direction</li> <li>• Prevention priorities</li> </ul>
<b>3.2S</b>	<p>Current analysis of gaps in critical health services, gaps in prevention services, and results of program evaluations are reported to LHJs; appropriate state, regional, and/or local stakeholders; and/or to state-level colleagues and used in building partnerships.</p>	<b>3.2L</b>	<p>Current analysis of gaps in local critical health services, gaps in prevention services, and results of program evaluations are reported to local stakeholders and/or to colleagues in other communities, regional partners, and statewide program colleagues and used in building partnerships.</p>
<b>3.3S</b>	<p>DOH collects information about successful community involvement and capacity building. These examples are shared with other DOH programs, LHJs, and stakeholders.</p>		<p>No corresponding measure</p>

**STANDARD 4: MONITORING AND REPORTING THREATS TO THE PUBLIC’S HEALTH**

A monitoring and reporting process is maintained to identify emerging threats to the public’s health. Investigation and control procedures are in place and actions documented. Compliance with regulations is sought through education, information, investigation, permit/license conditions, and appropriate enforcement actions.

STATE MEASURES		LHJ MEASURES	
<b>4.1S</b>	Health care providers and labs, including new licensees, are provided with information on notifiable conditions, time frames, and specific, current 24-hour DOH contact information in the form of a designated telephone line or a designated contact person.	<b>4.1L</b>	Health care providers and labs, including new licensees, are provided with information on notifiable conditions, time frames, and specific, current 24-hour LHJ contact information in the form of a designated telephone line or a designated contact person.
	No corresponding measure	<b>4.2L</b>	Health care providers receive information, through newsletters and other methods, about managing reportable conditions.
	No corresponding measure	<b>4.3L</b>	There is a process for identifying new providers in the community and engaging them in the reporting process.
	See <b>4.9S</b>	<b>4.4L</b>	Written protocols are maintained for receiving and managing information on notifiable conditions and other public health concerns. The protocols include role-specific steps to take when receiving information as well as guidance on providing information to the public. There is a formal description of the roles and relationship between communicable disease, environmental health, and other programmatic activities.
<b>4.2S</b>	Clinical labs are provided written protocols for the handling, storage, and transportation of specimens.		No corresponding measure
<b>4.3S</b>	Written procedures describe how expanded lab capacity is made readily available when needed for outbreak response, and there is a current list of labs having the capacity to analyze specimens.		No corresponding measure

STATE MEASURES		LHJ MEASURES	
<b>4.4S</b>	Written procedures are maintained and disseminated to LHJs and other stakeholders regarding how to obtain state or federal consultation and technical assistance. Assistance includes monitoring, reporting, and disease intervention management during outbreaks, environmental health events, or other public health emergencies. Written documentation demonstrates that consultation and technical assistance have been provided.		No corresponding measure
<b>4.5S</b>	A statewide database for notifiable conditions is maintained with uniform data standards and case definitions that are updated and published at least annually. Data are submitted to other state or federal agencies as required. Notifiable conditions data are summarized and disseminated to LHJs at least annually.	<b>4.5L</b>	A notifiable conditions tracking system documents the initial report, investigation, findings, and subsequent reporting to state and federal agencies.
<b>4.6S</b>	DOH leads statewide development of a standardized set of written protocols for notifiable conditions and outbreak investigation and control. Condition-specific protocols identify information about the disease, case investigation steps (including time frames for initiating investigations), reporting requirements, and contact and clinical management including referral to care. Evidence-based practices relating to the most effective population-based methods of disease prevention and control are provided to LHJs and other stakeholders for incorporation into protocols.	<b>4.6L</b>	Protocols identify information about specific conditions, case investigation steps (including time frames for initiating the investigation), reporting requirements, and contact and clinical management including referral to care. Evidence-based practices relating to the most effective population-based methods of disease prevention and control are incorporated into protocols.
<b>4.7S</b>	A process is in place for the public to report public health concerns. Information is referred, tracked, and/or shared with appropriate local, state, tribal, regional lead, and federal/national agencies.	<b>4.7L</b>	A process is in place for the public to report public health concerns. Information is referred, tracked, and/or shared with appropriate local, state, tribal, regional lead, and federal/national agencies.
	See <b>4.12S</b>	<b>4.8L</b>	A tracking system documents environmental health investigation/compliance activities from the initial report, through investigation, findings, and compliance action and subsequent reporting to state and federal agencies as required.

STATE MEASURES		LHJ MEASURES	
<b>4.8S</b>	Model plans, documentation, and evaluation templates for response to disease outbreaks, environmental health events, or other public health emergencies are developed and disseminated to LHJs. Information about best practices in environmental health investigation/ compliance is gathered and disseminated, including protocols, time frames, interagency coordination steps, hearing procedures, citation issuance, and documentation requirements.		No corresponding measure
<b>4.9S</b>	Written procedures delineate specific roles and responsibilities for DOH's response to disease outbreaks, environmental health events, or other public health emergencies. There is a formal description of the roles and relationship between communicable disease, environmental health, and other programmatic activities.		See <b>4.4L</b>
<b>4.10S</b>	SBOH and/or DOH lead statewide development of statutes and regulations that address notifiable conditions, environmental health risks, and other threats to the public's health.		No corresponding measure
<b>4.11S</b>	There are written procedures, which conform to state laws, to follow for DOH's investigation/compliance actions. The procedures specify case investigation steps (including time frames for initiating the investigation) and the type of documentation needed to take an enforcement action.	<b>4.9L</b>	There are written procedures to follow for investigation/compliance actions. The procedures specify case investigation steps (including time frames for initiating the investigation) and the type of documentation needed to take an enforcement action, based on local policies, ordinances, and state laws.
	No corresponding measure	<b>4.10L</b>	Protocols for the use of emergency biologics are available if needed.
	No corresponding measure	<b>4.11L</b>	Protocols for exercising legal authority for disease control (including quarantine and non-voluntary isolation) are available if needed.
<b>4.12S</b>	A tracking system documents DOH's investigation/compliance activities from the initial report, through investigation, findings, and compliance action, and subsequent reporting to state and federal agencies as required.		See <b>4.8L</b>

**STANDARD 5: PLANNING FOR AND RESPONDING TO PUBLIC HEALTH EMERGENECIES**

Emergency preparedness and response plans and efforts delineate roles and responsibilities in regard to preparation, response, and restoration activities as well as services available in the event of communicable disease outbreaks, environmental health risks, natural disasters, and other events that threaten the health of people.

STATE MEASURES		LHJ MEASURES	
<b>5.1S</b>	Written procedures are maintained and disseminated for how to obtain consultation and technical assistance regarding emergency preparedness for environmental health risks, natural disasters, or other threats to the public's health. Written documentation demonstrates that consultation and technical assistance have been provided.		No corresponding measure
	No corresponding measure	<b>5.1L</b>	A primary contact person(s) for health-risk reporting purposes is clearly identified in emergent communications to health providers and appropriate public safety officials.
<b>5.2S</b>	Environmental health risks, communicable disease outbreaks, and other public health emergencies are included in the DOH public health emergency preparedness and response plan (EPRP). The EPRP describes the specific roles and responsibilities for DOH programs/staff regarding response and management of disease outbreaks, environmental health risks, natural disasters, or other threats to the public's health. The DOH EPRP includes a section that describes processes for exercising the plan, including after-action review and revisions of the plan. Drills, after-action reviews, and revisions, if necessary, are documented.	<b>5.2L</b>	Environmental health risks, communicable disease outbreaks, and other public health emergencies are included in the local public health emergency preparedness and response plans (EPRP). The EPRP describes the specific roles and responsibilities for LHJ programs/staff regarding local response and management of disease outbreaks, environmental health risks, natural disasters, or other threats to the public's health. The LHJ EPRP includes a section that describes processes for exercising the plan, including after-action review and revisions of the plan. Drills, after-action reviews, and revisions, if necessary, are documented.
<b>5.3S</b>	DOH leads state-level public health emergency planning, exercises, and response/restoration activities and fully participates in planning, exercises, and response activities for other emergencies in the state that have public health implications. essential services.	<b>5.3L</b>	The LHJ leads community level-public health emergency planning, exercises, and response/restoration activities and fully participates in planning, exercises, and response activities for other emergencies in the community that have public health implications.

STATE MEASURES	
<b>5.4S</b>	Public health services that are essential for the public to access in different types of emergencies are identified. Public education and outreach include information on how to access these essential services.
<b>5.5S</b>	New employees are oriented to the EPRP, and the EPRP is reviewed annually with all employees.

LHJ MEASURES	
<b>5.4L</b>	Public health services that are essential for the public to access in different types of emergencies are identified. Public education and outreach includes information on how to access these essential services.
<b>5.5L</b>	New employees are oriented to the EPRP, and the EPRP is reviewed annually with all employees.

## STANDARD 6: PREVENTION AND EDUCATION

Prevention and education is a planned component of all public health programs and activities. Examples include wellness/healthy behaviors promotion and healthy child and family development, as well as primary, secondary, and tertiary prevention of chronic disease/disability, communicable disease (food/water/air/waste/vector-borne), and injuries. Prevention, health promotion, health education, and early intervention outreach services are provided.

STATE MEASURES		LHJ MEASURES	
<b>6.1S</b>	Key components of programs and activities are identified and strategies developed for prevention and health education activities, whether provided to individuals, families, or the community directly by DOH, LHJs, or through contracts with community partners. Strategies are evidence-based or promising practices whenever possible.	<b>6.1L</b>	Key components of programs and activities are identified and strategies developed for prevention and health education activities, whether provided to individuals, families, or the community directly by the LHJ or through contracts with community partners. Strategies are evidence-based or promising practices whenever possible.
<b>6.2S</b>	Prevention priorities are the foundation for establishing and delivering prevention, health promotion, early intervention, and outreach services to the entire population or at-risk populations. Data from program evaluation and the analysis of health data as well as statewide issues, funding availability, experience in service delivery, and information on evidence-based practices are used to develop prevention priorities and reduce health risks.	<b>6.2L</b>	Prevention priorities are the foundation for establishing and delivering prevention, health promotion, early intervention, and outreach services to the entire population or at-risk populations. Data from program evaluation and the analysis of health data as well as local issues, funding availability, experience in service delivery, and information on evidence-based practices are used to develop prevention priorities and reduce health risks.
<b>6.3S</b>	Prevention and health education information of all types (including technical assistance) is reviewed at least every other year and updated, expanded, or contracted as needed based on revised regulations, changes in community needs, evidence-based practices, and health data. There is a process to: <ul style="list-style-type: none"> <li>• Organize materials</li> <li>• Develop materials</li> <li>• Distribute or select materials</li> <li>• Evaluate materials</li> <li>• Update materials</li> </ul>	<b>6.3L</b>	Prevention and health education information of all types (including technical assistance) is reviewed at least every other year and updated, expanded, or contracted as needed based on revised regulations, changes in community needs, evidence-based practices, and health data. There is a process to: <ul style="list-style-type: none"> <li>• Organize materials</li> <li>• Develop materials</li> <li>• Distribute or select materials</li> <li>• Evaluate materials</li> <li>• Update materials</li> </ul>

STATE MEASURES		LHJ MEASURES	
<b>6.4S</b>	There is a range of methods in place to implement population-based prevention and health education in partnership with the community and stakeholders.	<b>6.4L</b>	There is a range of methods in place to implement population-based prevention and health education in partnership with the community and stakeholders.
<b>6.5S</b>	Written procedures are maintained and disseminated for how to obtain consultation and technical assistance for LHJs and other stakeholders regarding prevention policies and/or initiatives including the development, delivery, or evaluation of prevention programs and activities. Written documentation demonstrates that consultation and technical assistance have been provided.		No corresponding measure
<b>6.6S</b>	A statewide plan for prevention identifies efforts to link public and private partnerships into a network of prevention services.		No corresponding measure
<b>6.7S</b>	Prevention, health promotion, early intervention, and outreach services and activities are reviewed for compliance with evidence-based practice, professional standards, and state and federal requirements.		No corresponding measure
<b>6.8S</b>	DOH supports best use of available resources for prevention services through leadership, collaboration, and communication with partners. Information about prevention evaluation results is collected and shared statewide, and there is a process to inform LHJs and other stakeholders about prevention funding opportunities.		No corresponding measure

**STANDARD 7: HELPING COMMUNITIES ADDRESS GAPS IN CRITICAL HEALTH SERVICES**

Public health organizations convene, facilitate, and provide support for state and local partnerships intended to reduce health disparities and specific gaps in access to critical health services. Analysis of state and local health data is a central role for public health in this partnership process.

STATE MEASURES		LHJ MEASURES	
<b>7.1S</b>	A list of critical health services is established, and statewide access performance measures are established and tracked. Data is collected on the access performance measures, analyzed, and reported to the LHJs and other stakeholders.		No corresponding measure
<b>7.2S</b>	Summary information is provided to LHJs and other organizations about availability/numbers of licensed health care providers, facilities, and support services. Contact information is provided to LHJs regarding newly licensed/moved providers and facilities that are required to report notifiable conditions.		No corresponding measure
<b>7.3S</b>	Written descriptions are maintained and disseminated on how to obtain consultation and technical assistance for LHJs or communities; these describe how to gather and analyze information about barriers to accessing critical health services. Written documentation demonstrates that consultation and technical assistance have been provided.		No corresponding measure
	No corresponding measure	<b>7.1L</b>	Community groups and stakeholders, including health care providers, are convened to address health disparities and/or access to critical health services (including prevention services), set goals and take action based on information about local resources and trends. This process may be led by the LHJ or it may be part of a separate community process sponsored by multiple partners, including the LHJ.

STATE MEASURES	
	No corresponding measure
<b>7.2S</b>	Summary information is provided to LHJs and other organizations about availability/numbers of licensed health care providers, facilities, and support services. Contact information is provided to LHJs regarding newly licensed/moved providers and facilities that are required to report notifiable conditions.
<b>7.3S</b>	Written descriptions are maintained and disseminated on how to obtain consultation and technical assistance for LHJs or communities; these describe how to gather and analyze information about barriers to accessing critical health services. Written documentation demonstrates that consultation and technical assistance have been provided.
<b>7.4S</b>	Periodic surveys are conducted regarding the availability of critical health services and barriers to access. Gaps in access to critical health services are identified through analysis of the results of periodic surveys and other assessment information.
<b>7.5S</b>	Periodic studies regarding workforce needs and the effect on critical health services are analyzed and disseminated to LHJs and other stakeholders.

LHJ MEASURES	
<b>7.2L</b>	A local resource/referral list of private and public communicable disease treatment providers, providers of critical health services, and providers of preventive services is used along with assessment information to determine where detailed documentation and gap analysis of local capacity is needed.
	Periodic surveys are conducted regarding the availability of critical health services and barriers to access. Gaps in access to critical health services are identified through analysis of the results of periodic surveys and other assessment information.
	No corresponding measure
<b>7.3L</b>	Community groups and stakeholders, including health care providers, are convened to address health disparities and/or access to critical health services (including prevention services), set goals and take action based on information about local resources and trends. This process may be led by the LHJ or it may be part of a separate community process sponsored by multiple partners, including the LHJ.
	No corresponding measure

STATE MEASURES	
<b>7.6S</b>	Program and activity planning processes, contracts, and access initiatives reflect coordination of health service delivery among health care providers as well as linkage of individuals to medical homes.
<b>7.7S</b>	Information about access barriers affecting groups within the state is shared with other state agencies that pay for or support critical health services.
<b>7.8S</b>	Protocols are developed for implementation by LHJs, state agencies, and other stakeholders to maximize enrollment and participation in available insurance coverage.

LHJ MEASURES	
<b>7.4L</b>	Local planning processes, contracts, and access initiatives reflect coordination of health service delivery among health care providers as well as linkage of individuals to medical homes.
	No corresponding measure
	No corresponding measure

## STANDARD 8: PROGRAM PLANNING AND EVALUATION

Public health programs and activities identify specific goals, objectives, and performance measures and establish mechanisms for regular monitoring, reporting, and use of results.

STATE MEASURES		LHJ MEASURES	
<b>8.1S</b>	There is a planned, systematic process in which every program and activity, whether provided directly or contracted, has written goals, objectives, and performance measures. Professional requirements, knowledge, competencies, skills, and abilities for staff working in the program are identified. Consultation to LHJs or other stakeholders is addressed in goals, objectives, and/or performance measures.	<b>8.1L</b>	There is a planned, systematic process in which every program and activity, whether provided directly or contracted, has written goals, objectives, and performance measures. Professional requirements, knowledge, skills, and abilities for staff working in the program are identified.
<b>8.2S</b>	Program performance measures are tracked, and the data are analyzed and used to change and improve program activities and services and/or revise curricula/materials. Regular reports document the progress toward goals.	<b>8.2L</b>	Program performance measures are tracked, and the data are analyzed and used to change and improve program activities and services and/or revise curricula/materials. Regular reports document the progress toward goals.
<b>8.3S</b>	Additional sources of information, including experience from service delivery, funding availability, and information on evidence-based practices are used to improve services and activities. Experience from service delivery may include public requests, testimony to the SBOH, analysis of health data, and information from outreach, screening, referrals, case management, follow-up, investigations complaint/inspections, prevention, and health education activities.	<b>8.3L</b>	Additional sources of information, including experiences from service delivery, funding availability, and information on evidence-based practices are used to improve services and activities. Experience from service delivery may include public requests, testimony to the BOH, analysis of health data, and information from outreach, screening, referrals, case management, follow-up, investigations complaint/inspections, prevention, and health education activities.
<b>8.4S</b>	Where specific community collaborative projects are initiated, including those addressing access to critical health services, there is analysis of data; establishment of goals, objectives, and performance measures; and evaluation of the initiatives.	<b>8.4L</b>	Where specific community collaborative projects are initiated, including those addressing access to critical health services, there is analysis of data; establishment of goals, objectives, and performance measures; and evaluation of the initiatives.

STATE MEASURES	
<b>8.5S</b>	Customer service standards are established for all employees with a job function that requires them to interact with the general public, stakeholders, and partners. Staff and program performance measures are established, and evaluation of customer service standards is conducted.
<b>8.6S</b>	Workshops, other in-person trainings (including technical assistance), and other health education activities are evaluated by those organizing the activity to determine effectiveness. Curricula/materials are revised based on results.
<b>8.7S</b>	Statewide templates for documentation and data collection are provided for LHJs and other contractors to support performance measurement.
<b>8.8S</b>	Written descriptions are maintained and disseminated for how to obtain consultation and technical assistance for LHJs or state programs regarding program evaluation; written documentation demonstrates that consultation and technical assistance have been provided.
<b>8.9S</b>	An annual internal audit, using a sample of records (e.g., communicable disease investigations, environmental health, or other investigation/compliance actions) is done to gather data on timeliness and compliance with disease-specific protocols, investigation/compliance procedures, or other program protocols.
<b>8.10S</b>	Coordination is provided for a state and local debriefing to evaluate extraordinary events that required a multi-agency response; a written summary of evaluation findings and recommendations is disseminated statewide.

LHJ MEASURES	
<b>8.5L</b>	Customer service standards are established for all employees with job functions that require them to interact with the general public, stakeholders, and partners. Staff and program performance measures are established, and evaluation of customer service standards is conducted.
<b>8.6L</b>	Workshops, other in-person trainings (including technical assistance), and other health education activities are evaluated by those organizing the activity to determine effectiveness. Curricula/materials are revised based on results.
	No corresponding measure
	No corresponding measure
<b>8.7L</b>	An annual internal audit, using a sample of records (e.g., communicable disease investigations, environmental health, or other investigation/compliance actions) is done to gather data on timeliness and compliance with disease-specific protocols, investigation/compliance procedures or, other program protocols.
	No corresponding measure

STATE MEASURES		LHJ MEASURES	
<b>8.11S</b>	<p>An after-action evaluation is conducted for each significant outbreak, environmental event, natural disaster, tabletop exercise, or other public health emergency. Stakeholders are convened to assess how the event was handled, document what worked well, identify issues, and recommend changes in response procedures and other process improvements. The evaluation includes a review of the accessibility of essential public health services. Communicable disease, environmental health, and other public health staff are included in the evaluation, and feedback is solicited from appropriate stakeholders, such as hospitals, providers, and involved community organizations.</p>	<b>8.8L</b>	<p>An after-action evaluation is conducted for each significant outbreak, environmental event, natural disaster, tabletop exercise, or other public health emergency. Stakeholders are convened to assess how the event was handled, document what worked well, identify issues, and recommend changes in response procedures and other process improvements. The evaluation includes a review of the accessibility of essential public health services. Communicable disease, environmental health, and other public health staff are included in the evaluation, and feedback is solicited from appropriate stakeholders, such as hospitals, providers, and involved community organizations.</p>
<b>8.12S</b>	<p>Issues identified in after-action evaluations are used for process improvement in some or all of the following areas:</p> <ul style="list-style-type: none"> <li>• Monitoring and tracking processes</li> <li>• Disease-specific protocols</li> <li>• Investigation/compliance procedures</li> <li>• Laws and regulations</li> <li>• Staff roles</li> <li>• Communication efforts</li> <li>• Access to essential public health services</li> <li>• Emergency preparedness and response plans</li> <li>• Other state and/or local plans, such as facility/operations plan</li> </ul> <p>Recommended changes are addressed in future organizational goals and objectives.</p>	<b>8.9L</b>	<p>Issues identified in after-action evaluations are used for process improvement in some or all of the following areas:</p> <ul style="list-style-type: none"> <li>• Monitoring and tracking processes</li> <li>• Disease-specific protocols</li> <li>• Investigation/compliance procedures</li> <li>• Laws and regulations</li> <li>• Staff roles</li> <li>• Communication efforts</li> <li>• Access to essential public health services</li> <li>• Emergency preparedness and response plans</li> <li>• Other LHJ plans, such as facility/operations plan</li> </ul> <p>Recommended changes are addressed in future organizational goals and objectives.</p>

**STANDARD 9: FINANCIAL AND MANAGEMENT SYSTEMS**

Effective financial and management systems are in place in all public health organizations.

<b>STATE MEASURES</b>		<b>LHJ MEASURES</b>	
<b>9.1S</b>	The budget is aligned with the organization's strategic plan, reflects organizational goals, and is monitored on a regular basis. All available revenues are considered and collected.	<b>9.1L</b>	The budget is aligned with the organization's strategic plan, reflects organizational goals, and is monitored on a regular basis. All available revenues are considered and collected.
<b>9.2S</b>	Contracts are reviewed for legal requirements. Contracts are monitored for compliance with performance requirements.	<b>9.2L</b>	Contracts are reviewed for legal requirements. Contracts are monitored for compliance with performance requirements.

**STANDARD 10: HUMAN RESOURCE SYSTEMS**

Human resource systems and services support the public health workforce.

STATE MEASURES		LHJ MEASURES	
<b>10.1S</b>	Workplace policies promoting diversity and cultural competence, describing methods for compensation decisions, and establishing personnel rules and recruitment and retention of qualified and diverse staff are in place and available to staff.	<b>10.1L</b>	Workplace policies promoting diversity and cultural competence, describing methods for compensation decisions, and establishing personnel rules and recruitment and retention of qualified and diverse staff are in place and available to staff.
<b>10.2S</b>	Job descriptions are available to staff, performance evaluations are done, and performance improvement plans exist that promote learning and development for individual employees. Each employee has a training plan that is updated annually and includes the training needed for competent performance of required job duties.	<b>10.2L</b>	Job descriptions are available to staff, performance evaluations are done, and performance improvement plans exist that promote learning and development for individual employees. Each employee has a training plan that is updated annually and includes the training needed for competent performance of required job duties.
<b>10.3S</b>	The organization has a written description of how it assures that employees have the appropriate licenses, credentials, and experience to meet job qualifications and perform job requirements.	<b>10.3L</b>	The organization has a written description of how it assures that employees have the appropriate licenses, credentials, and experience to meet job qualifications and perform job requirements.

STATE MEASURES	
<b>10.4S</b>	<p>Staff training is provided, as appropriate, including but not limited to the following topics:</p> <ul style="list-style-type: none"> <li>• Assessment and data analysis</li> <li>• Program evaluation to assess program effectiveness</li> <li>• Confidentiality and HIPAA requirements</li> <li>• Communications, including risk and media relations</li> <li>• State laws/regulations/policies including investigation/compliance procedures</li> <li>• Specific EPRP duties</li> <li>• Community involvement and capacity- building methods</li> <li>• Prevention and health promotion methods and tools</li> <li>• Quality improvement methods and tools</li> <li>• Customer service</li> <li>• Cultural competency</li> <li>• Information technology tools</li> <li>• Leadership</li> <li>• Supervision and coaching</li> <li>• Job-specific technical skills</li> </ul> <p>Training is evidenced by documentation of learning content and specific staff participation or completion.</p>
<b>10.5S</b>	<p>There are written policies regarding confidentiality, including HIPAA requirements, and every employee required per policies has signed a confidentiality agreement.</p>
<b>10.6S</b>	<p>Facilities and work processes are compliant with ADA requirements.</p>

LHJ MEASURES	
<b>10.4L</b>	<p>Staff training is provided, as appropriate, including but not limited to the following topics:</p> <ul style="list-style-type: none"> <li>• Assessment and data analysis</li> <li>• Program evaluation to assess program effectiveness</li> <li>• Confidentiality and HIPAA requirements</li> <li>• Communications, including risk and media relations</li> <li>• State and local laws/regulations/policies including investigation/compliance procedures</li> <li>• Specific EPRP duties</li> <li>• Community involvement and capacity-building methods</li> <li>• Prevention and health promotion methods and tools</li> <li>• Quality improvement methods and tools</li> <li>• Customer service</li> <li>• Cultural competency</li> <li>• Information technology tools</li> <li>• Leadership</li> <li>• Supervision and coaching</li> <li>• Job-specific technical skills</li> </ul> <p>Training is evidenced by documentation of learning content and specific staff participation or completion.</p>
<b>10.5L</b>	<p>There are written policies regarding confidentiality, including HIPAA requirements, and every employee required per policies has signed a confidentiality agreement.</p>
<b>10.6L</b>	<p>Facilities and work processes are compliant with ADA requirements.</p>

## STANDARD 11: INFORMATION SYSTEM

Information systems support the public health mission and staff by providing infrastructure for data collection, analysis, and rapid communication.

STATE MEASURES		LHJ MEASURES	
<b>11.1S</b>	Information technology documentation describes processes in place for assuring protection of data (passwords, firewalls, backup systems) and data systems to address security, redundancy, and appropriate use. There is documentation of monitoring these processes for compliance.	<b>11.1L</b>	Information technology documentation describes processes in place for assuring protection of data (passwords, firewalls, backup systems) and data systems to address security, redundancy, and appropriate use. There is documentation of monitoring these processes for compliance.
<b>11.2S</b>	Computer hardware, software (e.g., word processing, spreadsheets with basic analysis capabilities, databases, email, and Internet access), and trained staff are available to assist public health staff.	<b>11.2L</b>	Computer hardware, software (e.g., word processing, spreadsheets with basic analysis capabilities, databases, email, and Internet access), and trained staff are available to assist public health staff.
<b>11.3S</b>	Strategies for use of future technologies are part of the organization's IS plan.	<b>11.3L</b>	Strategies for use of future technologies are part of the organization or county IS plan.
<b>11.4S</b>	<p>The DOH program website contains, but is not limited to:</p> <ul style="list-style-type: none"> <li>• 24-hr contact number for reporting health emergencies</li> <li>• Notifiable conditions line and/or contact</li> <li>• Health data and core indicator information</li> <li>• How to obtain technical assistance and consultation from DOH</li> <li>• Links to legislation, regulations, codes, and ordinances</li> <li>• Information and materials on communicable disease, environmental health, and prevention activities or links to other sites where this information is available</li> <li>• A mechanism for gathering user feedback on the usefulness of the website</li> </ul>	<b>11.4L</b>	<p>The local jurisdiction (may be part of county) website contains, but is not limited to:</p> <ul style="list-style-type: none"> <li>• 24-hr contact number for reporting health emergencies</li> <li>• Notifiable conditions line and/or contact</li> <li>• Health data and core indicator information</li> <li>• How to obtain technical assistance and consultation from the LHJ</li> <li>• Links to legislation, regulations, codes, and ordinances</li> <li>• Information and materials on communicable disease, environmental health, and prevention activities or links to other sites where this information is available</li> </ul>

**STATE MEASURES**

**11.5S** Written policies, including data-sharing agreements, govern the use, sharing, and transfer of data within DOH and with LHJs and partner organizations; all program data are submitted to local, state, regional, and federal agencies in a confidential and secure manner.

**LHJ MEASURES**

**11.5L** Written policies, including data-sharing agreements, govern the use, sharing, and transfer of data within the LHJ and among LHJs and partner organizations, and all program data are submitted to local, state, regional, and federal agencies in a confidential and secure manner.

## STANDARD 12: LEADERSHIP AND GOVERNANCE

Leadership and governance bodies set organizational policies and direction and assure accountability.

STATE MEASURES		LHJ MEASURES	
<b>12.1S</b>	<p>The State Board of Health:</p> <ul style="list-style-type: none"> <li>• Orients new members to SBOH and sponsors orientation for local BOHs</li> <li>• Sets operating rules including guidelines for communications with senior managers in local and state organizations</li> <li>• Votes on and documents actions it takes</li> </ul>	<b>12.1L</b>	<p>The governing body/local board of health:</p> <ul style="list-style-type: none"> <li>• Orients new members</li> <li>• Sets operating rules including guidelines for communications with senior managers</li> <li>• Votes on and documents actions it takes</li> </ul>
	No corresponding measure	<b>12.2L</b>	<p>The BOH receives a report annually on health data that includes the local public health indicators as well as data about community health status, communicable disease, environmental health risks and related illness, and access to critical health services, with recommended actions for health policy decisions. Actions taken by the BOH are documented.</p>
	No corresponding measure	<b>12.3L</b>	<p>Progress toward program goals is reported annually to the BOH via a single compiled report or multiple program reports throughout the year.</p>
	No corresponding measure	<b>12.4L</b>	<p>Recommendations based on evaluation of each significant outbreak, environmental event, natural disaster, tabletop exercise, or other public health emergency are reported to the BOH.</p>
<b>12.2S</b>	<p>There are written guidelines for effective assessment and management of clinical and financial risk; the organization has obtained insurance coverage specific to assessed risk.</p>	<b>12.5L</b>	<p>There are written guidelines for effective assessment and management of clinical and financial risk; the organization has obtained insurance coverage specific to assessed risk.</p>
<b>12.3S</b>	<p>An organization-wide strategic/operations plan is developed that includes:</p> <ul style="list-style-type: none"> <li>• Vision and mission statements</li> <li>• Goals, objectives, and performance measures</li> </ul>	<b>12.6L</b>	<p>An organization-wide strategic/operations plan is developed that includes:</p> <ul style="list-style-type: none"> <li>• Vision and mission statements</li> <li>• Goals, objectives, and performance measures for priorities or initiatives</li> </ul>

STATE MEASURES	
<b>12.4S</b>	<p>The strategic plan includes objectives regarding:</p> <ul style="list-style-type: none"> <li>• Assessment activities and the resources needed, such as staff or outside assistance, to perform the work</li> <li>• Use of health data to support health policy and program decisions</li> <li>• Addressing communicable disease, environmental health events, or other public health emergencies, including response and communication issues identified in the course of after-action evaluations</li> <li>• Prevention priorities intended to reach the entire population or at-risk populations in the population</li> </ul>
	No corresponding measure
<b>12.5S</b>	<p>There is a written quality improvement plan in which:</p> <ul style="list-style-type: none"> <li>• Specific objectives address opportunities for improvement identified through health data including the core indicators, program evaluations, outbreak response or after-action evaluations or the strategic planning process</li> <li>• Objectives may be program-specific and tied to the program evaluation process, or they may reach across programs and activities for operational improvements that impact much of the organization</li> <li>• Objectives identify time frames for completion and responsible staff</li> <li>• Objectives have performance measures established</li> </ul>

LHJ MEASURES	
<b>12.7L</b>	<p>The strategic plan includes objectives regarding:</p> <ul style="list-style-type: none"> <li>• Assessment activities and the resources needed, such as staff or outside assistance, to perform the work</li> <li>• Use of health data to support health policy and program decisions</li> <li>• Addressing communicable disease, environmental health events, or other public health emergencies, including response and communication issues identified in the course of after-action evaluations</li> <li>• Prevention priorities intended to reach the entire population or at-risk populations in the population</li> </ul>
<b>12.8L</b>	The strategic plan is adopted by the BOH.
<b>12.9L</b>	<p>There is a written quality improvement plan in which:</p> <ul style="list-style-type: none"> <li>• Specific objectives address opportunities for improvement identified through health data including the core indicators, program evaluations, outbreak response or after-action evaluations or the strategic planning process</li> <li>• Objectives may be program-specific and tied to the program evaluation process, or they may reach across programs and activities for operational improvements that impact much of the organization</li> <li>• Objectives identify time frames for completion and responsible staff</li> <li>• Objectives have performance measures established</li> </ul>

## STATE MEASURES

### 12.6S

Annual review of the quality improvement plan includes:

- Performance measures are tracked, reported, and used to assess the impact of improvement actions
- Meaningful improvement is demonstrated in at least one objective
- Revision of the plan with new, revised, and deleted objectives is made based upon the review

## LHJ MEASURES

### 12.10L

Annual review of the quality improvement plan includes:

- Performance measures are tracked, reported, and used to assess the impact of improvement actions
- Meaningful improvement is demonstrated in at least one objective
- Revision of the plan with new, revised, and deleted objectives is made based upon the review



## **ACKNOWLEDGMENTS**

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## **SPECIAL THANKS TO**

### **MCPH Healthcare Consulting**

*for planning and conducting the 2008 Performance Review*

Barbara Mauer  
Marlene Mason  
Diane Altman-Dautoff  
John Freeman

### **Brewer Consulting**

Brett Brewer

### **Hilary Gillette-Walch**

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