

Draft Local Public Health Indicators

**Local Public Health Indicators
Subcommittee Report**

1/30/07

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I. Introduction

In spring 2006, the Washington State Public Health Improvement Partnership (PHIP) Performance Management and Key Health Indicators Committees established the Public Health Indicators (PHI) subcommittee. The work of the subcommittee addresses both the Recommendation from the 2005 Standards Assessment of Performance Overall System Report and the law for the Public Health Improvement Plan. This work is also part of the Multi-state Learning Collaborative funded by the Robert Wood Johnson Foundation and of the ongoing cycle of performance management and improvement for public health in Washington State.

A. Charge and Membership of the PHI Subcommittee

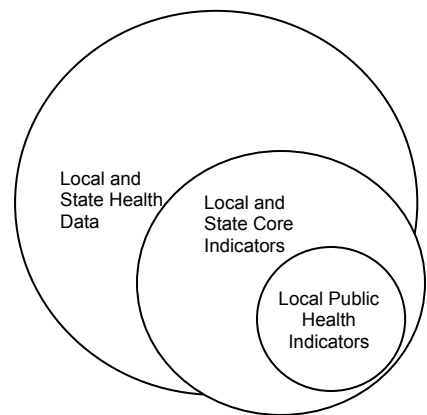
The purpose of the subcommittee was to identify a set of local public health indicators to measure selected results and outcomes of the public health system in Washington State. The audience for this work includes legislators, Board of Health members and other policy makers as well as public health management.

The subcommittee included individuals from state and local levels, from nursing, environmental health, assessment, administration, and from related public health organizations, such as the Washington State Association of Local Health Officials (WSALPHO). The subcommittee (membership list in Attachment A) was chaired by Lyndia Vold from Spokane Regional Health Department, staffed by Mary Looker from DOH and facilitated by Marni Mason, from MCPP Healthcare Consulting.

B. Important Definitions Used by the Subcommittee

Early in its work, the subcommittee realized that establishing common terminology was important to accomplish the subcommittee charge. The Performance Management Glossary [Attachment B] was used extensively to clarify the use of terms related to the work of the subcommittee. In a few instances the subcommittee developed the definition used in its work.

Local Public Health Indicators Set: is a subset of local or statewide health data and local or statewide core indicators. They are those data sets that have been selected for use statewide, to be reported by DOH on a consistent basis for all LHJs as well as statewide. Whenever possible, they are accompanied by benchmark data from other LHJs, other states, and/or national data. [*Program Evaluation* data may contribute to this data set.]



Health Status: measures the current state of a specific aspect of health.

Health Determinants: include the social and economic environment, the physical environment, and the person's individual characteristics and behaviors all of which affect health status over time (*World Health Organization*).

Public Health System: The PHI/PM Subcommittee defined the “Public Health System” related to the local public health indicators as local and state public health agencies, their communities and partners where public health activities control or influence the results and outcomes.

C. Socio-demographic Framework

Each community is different with changing demographics and needs, including its own unique set of public health problems.

The Centers for Disease Control and Prevention have studied this issue along with many national and international organizations. Great bodies of research and data support the link between socioeconomic factors and the health of a population. In the Health of Washington State report, the chapter on Social Determinants of Health gives a thorough discussion of the relationship between socioeconomic position and health.¹

Public health departments continue to pursue efforts to equalize the population’s health by targeting their services and providing outreach to vulnerable populations. One source sums up vulnerable populations as “social groups who have an increased susceptibility or higher than the national average risk for health-related problems. A variety of populations and groups in society are vulnerable to health disparities.”² Vulnerability can be caused by a combination of underlying reasons, including financial, place of residence, health, age, cultural differences, functional or developmental status, or ability to communicate effectively. In addition, personal characteristics, such as race, ethnicity, and gender can contribute to vulnerability.^{3, 4}

The vulnerable populations in the United States have led the government to pursue goals around eliminating health disparities.⁵ Vulnerable populations are groups of individuals in various categories who tend to have poorer health status and more medical needs than the general population.⁶

The socio-demographic picture of each county has a strong hand in the health of its citizens.

D. Criteria Used for Selection of Local Public Health Indicators

The subcommittee established criteria for selecting the set of local public health indicators. These criteria were included on an indicator matrix [Attachment C] and the subcommittee evaluated each potential indicator against all 11 criteria.

These criteria are:

¹ Washington State Department of Health, The Health of Washington State, 2002.

² UCLA School of Nursing, *What are Vulnerable Populations*, 1999-2000.

³ Agency for Health Care Policy and Research, January 1999.

⁴ President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry, July 1998.

⁵ Healthy People 2010, U.S. Department of Health and Human Services and Office of Public Health and Science

⁶ U.S. Department of Health and Human Services, Health Resources and Services Administration, Community Health Status Report, July 2000.

1. Measures an important aspect, result or outcome of public health's work Rated by high –public health can take an active role, or medium-public health will coordinate with others who are responsible, or low- public health is a strong advocate but is not directly involved.
2. Population-based
3. Measurable (Able to be defined in standard, specific terms)
4. Feasible to collect, not too expensive
5. Actionable, meaning that actions or interventions could be taken by public health staff to improve performance against the measure. Measures are actionable if public health has control or influence.
6. Can be reported routinely at least 90% of local sites and aggregated to the regional and state level, compared to the nation when possible
7. Indicator may be either a measurement of health determinants and health status,
8. Trend data available to monitor direction of change with annual to biennial updates
9. Links to and is consistent with local, state, and national measures, like Healthy People 2010
10. When available, gives demographic detail – age, gender, race/ethnicity, education, and income level – to identify disparities
11. Indicator is understandable and does not require extensive explanation

While the criteria were consistently applied to each potential indicator, it is difficult to know the true extent of control or influence that a local jurisdiction can have on an individual's behavior and the related impact on some of the health indicators. Secondly data validity was added to the criteria matrix chart and became a critical part of the discussion.

E. Indicators Selected by Five Groups

The first round of selecting indicators was conducted by 5 small groups within the subcommittee, and then the full subcommittee narrowed the set of draft health indicators based on prioritizing and eliminating redundancy. The small groups were focused on indicators for Access, Communicable Disease, Epidemiology, Environmental Health, Maternal and Child Health, and Prevention and Health Promotion.

F. Feedback on Draft Set of Local Public Health Indicators

After the draft set of the indicators was completed, the PHI subcommittee members attended multiple leadership forums and other meetings to get feedback from a broad group of state and local public health staff, including the Key Health Indicator (KHI) Committee, the Local Assessment Group, Public Health Executive Leadership Forum (PHELF), Performance Management (PM) Committee, the Environmental Health Directors, the Public Health Nursing Directors, WSALPHO, and DOH Senior Management Team. The subcommittee considered all the feedback and

recommended a final set of local public health indicators to the PM and KHI Committees for adoption.

G. How this work relates to other work.

The indicators are intended to be a subset of county level data to give a snapshot of the health issues. The list is not intended to set priorities for the counties but can serve as a tool to track and identify the most pressing health concerns. There may be and should be a broader set of infectious and communicable diseases that are monitored and reported on locally

In 2005, the PHIP Report Card on Health was published using health determinants to look at overall health. State only data was used and grades were assigned comparing WA state to the US and whether we were getting worse or showing improvement and whether there were disparities among racial and economic groups. The PHI will be focused on county level data and uses rates to measure changes in subsequent years.

II. Local Public Health Indicators

The table below lists the recommended set of local public health indicators. The following section contains detailed description of each indicator and discussion of data quality and other issues.

1. Rate of Reported Chlamydia Infections (Females Age 15-24 Years)	12. % 10th Graders who Report Alcohol Consumption in Past 30 Days	23. Asthma Hospitalization Rates (Age 0-17 Years)
2. % Reported Chlamydia Treatment (Females Age 15-24 Years)	13. % Adults who Report Binge Drinking on 1 or > Occasion in Past 30 Days	24. % Adults in Household who Report Unmet Medical Need due to Cost
3. % Reported Influenza Vaccine during Previous Year (Age 65+ years)	14. % Adults who Report Diagnosis of Diabetes	25. % Adults who Report Usual Source of Health Care
4. % Children on Medicaid with Up-to-Date Immunization Status	15. % Adults who Report 14 or > Days of Poor Mental Health in Past 30 Days	26. % Adults who Report having Visited Dentist in Past Year
5. Expected Years of Healthy Life at Age 20	16. Unintentional Poisoning Hospitalization Rates per 100,000 (All Ages)	27. % Adults who Report Receiving Preventive Cancer Screenings (Breast, Cervical, Colorectal)
6. % 10th Graders who Report Smoking in Last 30 Days	17. % Women Living in WA who Received Prenatal Care during 1st Trimester	28. % Adults who Report having health Insurance
7. % Adults who Report Smoking Every Day or Some Days	18. % Pregnant Women who Smoke during 2nd/3rd Trimester	29. % Children who are reported as having insurance
8. % Adults who Report Meeting Moderate or Vigorous Physical Activity	19. Birth Rates of Females (Age 15-17 Years)	30. % Permitted Solid Waste Facilities in Compliance with Permit Conditions
8. % 10th Graders who are Overweight	20. % Low Birth Weight among Singletons	31. % Inspections of Permanent Food Establishments with 35 or > Critical Violations
10 % Adults who are Obese and Overweight	21. % 10th Graders who Report Meeting Vigorous Physical Activity	32. % Identified On-Site Sewage System Failures Initiated with Corrective Action within 2 Weeks
11. % Adults who Report Eating Fruits and Vegetables 5 or More Times per Day	22. Unintentional Injury Hospitalization Rates (Age 0-17 Years)	

The Subcommittee acknowledges the need for better data collection and tracking to report on immunizations, communicable diseases, and water systems.

III. Detailed Description of Local Public Health Indicators

The recommended set of Local Public Health Indicators is a mix of health status indicators and health determinant indicators. The indicators address the five key aspects of public health:

- Access
- Communicable Disease and Epidemiology,
- Environmental Health,
- Maternal and Child Health, and
- Prevention and Health Promotion

1. Reported Chlamydia Infections in females 15-24 years of age

Data: DOH STD Case Reports Rate is episodes (not individuals) per 100,000 population per year. Age group focus is females 15-24 years as the reported rates of Chlamydia are highest among young females.

Data availability: stable numbers are generally available by county, with a total of 12,000-15,000 cases reported state wide. For counties under 50,000 the population rates would be too low to reliably examine trends. Two counties average less than 5 reported cases annually. Outreach and screening programs can increase rates of Chlamydia in a county.

Rationale: This age group is recommended by Infectious Disease and Reproductive Health (IDRH). Females who receive reproductive services are screened routinely. Limitation of data: if the patient doesn't report address accurately, however, identification used with payment will often pick up the accurate address.

2. Percent reported Chlamydia treatment for females 15-24 years of age

Data: DOH STD Case Reports. Rate is treated cases per total reported cases reported by county of residence. One limitation of data is if the patient doesn't report address accurately, however, identification used with payment will often pick up the accurate address.

Rationale: This age group is recommended by Infectious Disease and Reproductive Health (IDRH).

3. Influenza vaccine during previous year for 65+

Data: BRFSS question: A flu shot is an influenza vaccine injected in your arm. During the past 12 months have you had a flu shot? Data is available with 95% confidence intervals of no more than +or – 5% for 8 counties from BRFSS, combining 2003-2005 data. Numbers are small so may need to combine years: 2003-2005 (3 years) included county over sample of counties with no more than 7000-8000 population.

Rationale: Ninety percent of all influenza-related hospitalizations and deaths occur among people aged 65+.

4. Percent of Medicaid (Healthy Options) children who are adequately immunized (4 doses DTP, 3 doses polio, 1 dose MMR, 3 doses Hib, 3 doses HepB and one dose Varicella) by two years of age

Data: Healthy Options maintains several performance indicators in its contracts with health plans. Childhood immunization is one of the ongoing indicators. The data is collected by health plans following a rigid and detailed protocol that is established by a national committee. Plans may either report on all eligible children or just on a sample. Each plan's submission is audited by a certified 3rd party to ensure the plans methods meet the standards. When the plans submit their data to HRSA, they include information on residence of the child and number of children covered. Methods to aggregate data from multiple plans need to be developed.

Rationale: Childhood immunizations have provided one of the greatest improvements in public health by controlling serious conditions such as measles, polio, diphtheria and tetanus. Vaccine coverage, which can be compared across states, is based on the proportion of children receiving recommended vaccinations by a specified age. The National Immunization Survey does not have a big enough sample to calculate county level coverage rates. As a data source, CHILD Profile is still building participation in the registry. Since not all providers in the state are participating, available data may not be representative or complete so do not describe vaccine coverage for Washington's children. Eventually, the registry will provide our state with immunization rates.

5. Expected years of healthy life at age 20

Data: BRFSS & Vital statistics Death Certificate Data will provide raw data.

The measure will need to be calculated. This indicator was also used in the report card. This is measured in "number of years," not a rate, so numerator/denominator don't apply. It is calculated by adjusting life expectancy derived from death certificate data with health status measured by the BRFSS question, "Would you say your health in general is excellent, very good, good, fair, or poor?" The method used is described in U.S. Centers for Disease Control and Prevention, National Center for Health Statistics (CDC-NCHS) Statistical Notes, Number 21 August 2001. The method is slightly modified because the measure of health status is available only for people age 18 and older. Thus, we calculate years of expected healthy life (referred to as "healthy life expectancy" in the CDC-NCHS report) as the number of additional years a 20 year-old is expected to live in good, very good, or excellent health.

Rationale: "Years of healthy life" is an overall measure of the quality of life expected for people at age 20.

6. Percent 10th graders who report smoking in last 30 days

Data: Healthy Youth Survey. County data are available for most counties. In 2004, for grade 10, there were 10 counties with response rates high enough to assure ability to generalize (response rate of 70% or higher), 21 counties with response rates that should be accompanied by a caution (response rate of 40%-69%), and 8 counties that do not have county level reports posted on the HYS

website due to small size or response rates below 40%. Best surveying time is 10th grade as high-risk students may drop out of school before grade 12. The subcommittee has agreed to report counties with 40% and greater response rates, accompanied by a data note. Of the counties with at least 70% response rates, only about half also have 95% confidence intervals of no more than $\pm 5\%$ so it may be necessary to combine years (e.g. 2004 and 2006) for small counties. Since participation rates vary from year to year, there will be fewer counties with trend data than data in a particular year. Availability of local data depends on funding levels; funding for county level HYS data is currently provided mainly by the Tobacco Prevention and Control program.

Rationale: Cigarette smoking is the single most preventable cause of disease and death in the United States. Tobacco use is a childhood-onset disease. Magazine advertisements, movies, and retail marketing have shaped a youth culture that views tobacco use as glamorous, social, grown-up, and rebellious. Forty-five children in Washington start using tobacco every day and one-third of them will eventually die from it.

This measure helps evaluate the prevalence of smoking among youth in high school. Using the 10th grade measure covers the most representative group. Some of the youth most at risk will drop out of high school before 12th grade.

According to the 2004 Healthy Youth Survey, youth smoking in Washington has dropped to an all time low since the state began tracking it in 1990. More than half of Washington kids surveyed had practiced saying no to tobacco in school. About half of kids surveyed said they had been taught an anti-tobacco lesson in school at least four times. Nearly 80 percent of kids who got those lessons said the lessons made them think about whether or not to use tobacco. Based on 2004 data, smoking is down for all grades: for sixth-graders smoking is down 57 percent; for eighth-graders smoking is down 49 percent; for tenth-graders smoking is down 48 percent; and for twelfth-graders smoking is down 44 percent. For tenth-graders that means the rate has dropped from 25 percent in 1999 to 13 percent in 2004.

7. Percent of adults who report meeting moderate or vigorous physical activity level

Data: BRFSS- questions are very extensive asking about moderate activities time and duration and vigorous physical activities for when one is not working and one's physical activities on the job.

Rationale: This measure is used on the Report Card and follows the CDC's recommendations for moderate or vigorous physical activity through work or leisure. Approximately 1/3 of adults are not physically active at levels recommended for maintaining good health. The Healthy People 2010 target goals are: 30% for moderate physical activity and 30% for vigorous physical activity. A person could report meeting either or both of the moderate and physical activity goals. The 30% rate for either moderate or physical activity is the minimum level in meeting the target and would increase to a level less than 60% when the two are combined. The Healthy People 2010 target goals are for leisure time activity only and so would not be

comparable to a measure combining work and leisure activity, but a measure of only leisure time activity does not accurately represent economic disparities in overall physical activity.

8. Percent of adults who report binge drinking on one or more occasion in past 30 days

Data: BRFSS. Question: Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 drinks for men /4 drinks for women on one or more occasion?

Rationale: This measure is used on the Report Card. We cannot measure alcohol abuse directly, but people who binge drink are at risk for alcohol abuse. This type of drinking is related to other public health issues, such as drinking and driving, domestic violence, and crime.

9. Percent of Adults who report smoking everyday or some days

Data: BRFSS: Weighted number of adults who report smoking every day or some days in response to the question” Do you now smoke cigarettes every day, some days or not at all?:

Rationale: Cigarette smoking is the single most preventable cause of disease and death in the United States. Smoking results in more deaths each year in the United States than AIDS, alcohol, cocaine, heroin, homicide, suicide, motor vehicle crashes, and fires—combined. Smoking is a major risk factor for heart disease, stroke, lung cancer, and chronic lung diseases—all leading causes of death. Smoking during pregnancy can result in miscarriages, premature delivery, and sudden infant death syndrome. Other health effects of smoking result from injuries and environmental damage caused by fires. Tobacco-related deaths number more than 430,000 per year among U.S. adults, representing more than 5 million years of potential life lost. Direct medical costs attributable to smoking total at least \$50 billion per year.

In 1998, 24 percent of adults in the United States were current cigarette smokers. In 1998 in Washington State, 21.4% of adults were current smokers.

Environmental tobacco smoke (ETS) increases the risk of heart disease and significant lung conditions, especially asthma and bronchitis in children. ETS is responsible for an estimated 3,000 lung cancer deaths each year among adult nonsmokers.

10. Percent of adults who are obese or overweight

Data: BRFSS using Body Mass Index (weight in kilograms divided by height in meters squared. ($BMI = \text{kg}/\text{m}^2$) Respondents with $BMI \geq 30$ are coded as obese and respondents with $BMI \geq 25$ and < 30 are coded as overweight.

Rationale: This prevalence measure is used in the Report Card. Being at an unhealthy weight is related to many morbidity and mortality issues. There is some caution needed with this measure as its accuracy can be questionable due to body

types, muscle mass and other factors not considered, but is the best measure we have at this time. The definition and calculation should be given to make this more understandable.

11. Percent of adults who report diagnosis of diabetes

Data: BRFSS. Weighted number of adults (population estimate) who report that a doctor told them they have diabetes.

Rationale: Diabetes is one of the top 10 causes of death and is related to unhealthy behaviors, such as being overweight, inactive, and having poor nutrition. This prevalence measure of health status was selected due to the increasing trend and unhealthy behaviors that can be targeted by public health.

12. Percent of adults who report 14 or more days of poor mental health in past month

Data: BRFSS question based on weighed number of adults (population estimate) who report 14 or more days of poor mental health in past month. This measure is used in the Report Card. This measure has yielded similar results to longer measures of recent mental health (CDC. Self-Reported Frequent Mental Distress among Adults – United States, 1993-1996. MMWR 1998; 47:326-331).

Rationale: Access to mental health services can address early concerns of stress, depression, and anxiety disorders in a preventative setting. One's mental health/wellness is critical to personal well-being, family and interpersonal relationships, and one's contribution to society. . Poor mental health is associated with disability and suicide.

13. Percent of 10th graders who report alcohol consumption in past 30 days

Data: Healthy Youth Survey. County data are available for most counties. In 2004, for grade 10, there were 10 counties with response rates high enough to assure ability to generalize (response rate of 70% or higher), 21 counties with response rates that should be accompanied by a caution (response rate of 40%-69%), and 8 counties that do not have county level reports posted on the HYS website due to small size or response rates below 40%. Best surveying time is 10th grade as high-risk students may drop out of school before grade 12. The subcommittee has agreed to report counties with 40% and greater response rates, accompanied by a data note. Of the counties with at least 70% response rates, only about half also have 95% confidence intervals of no more that $\pm 5\%$ so it may be necessary to combine years (e.g. 2004 and 2006) for small counties. Since participation rates vary from year to year, there will be fewer counties with trend data than data in a particular year. Availability of local data depends on funding levels; funding for county level HYS data is currently provided mainly by the Tobacco Prevention and Control program. This measure is used in the report Card and was included on the 2002 and 2004 HYS and the 2000 Washington State Survey of Adolescent Health Behaviors.

Rationale: The four leading causes of death among 15-20 year olds are vehicle crashes, homicides, suicides, and other unintentional injuries; alcohol is a factor in

many of these. In fact, among licensed drivers, underage drinkers are involved in fatal crashes at twice the rate of adult drivers. The earlier a person starts drinking, the higher their chances of developing an alcohol use disorder at some time in their life. Also, there is growing evidence that early alcohol use leads to brain damage. .Source: *Reducing Underage Drinking: A Collective Responsibility. National Research Council and Institute of Medicine, 2004.*

14. Percent of 10th graders who are overweight-BMI

Data: Healthy Youth Survey. County data are available for most counties. In 2004, for grade 10, there were 10 counties with response rates high enough to assure ability to generalize (response rate of 70% or higher), 21 counties with response rates that should be accompanied by a caution (response rate of 40%-69%), and 8 counties that do not have county level reports posted on the HYS website due to small size or response rates below 40%. Best surveying time is 10th grade as high-risk students may drop out of school before grade 12. The subcommittee has agreed to report counties with 40% and greater response rates, accompanied by a data note. Of the counties with at least 70% response rates, only about half also have 95% confidence intervals of no more than $\pm 5\%$ so it may be necessary to combine years (e.g. 2004 and 2006) for small counties. Since participation rates vary from year to year, there will be fewer counties with trend data than data in a particular year. Availability of local data depends on funding levels; funding for county level HYS data is currently provided mainly by the Tobacco Prevention and Control program. This measure is used in the report Card and was included on the 2002 and 2004 HYS and the 2000 Washington State Survey of Adolescent Health Behaviors.

Rationale: Obesity in adolescence is associated with negative physical, psychological, and social consequences. Extra weight acquired during adolescence may persist into adulthood and increase the risk later in life for heart disease, gall bladder disease, some types of cancer, and osteoarthritis of the weight-bearing joints. In adolescence, overweight and obesity have been associated with an increased risk for diabetes, liver disease, high cholesterol, and functional limitations; and poorer general health than kids who were not overweight or obese (Deitz, 1998; Swallen, Reither, Haas and Meier, 2005).

15. Percent of adults who eat fruits and vegetables 5 or more times per day

Data: BRFSS question based on a weighted number of adults 18+ years (population estimate) who report eating fruits and vegetables 5 or more times per day.

Rationale: This indicator is used in the Report Card. There is substantial evidence that suggests consuming at least five daily servings of fruits and vegetables can prevent many cancers and possibly coronary heart disease and stroke. The BRFSS measures “times per day, not servings” as serving size is hard for people to understand. Based on the 23% eating fruits and vegetables 5 times each day in 2003, DOH estimates that about half of adults meet the recommended 5 servings a day leaving room for improvement.

16. Unintentional poisoning hospital rates per 100,000 (all ages)

Data: This indicator is based on hospital discharge data collected by the Comprehensive Hospital Abstract Reporting System (CHARS). There are no comparable national data. CHARS data are collected by zip code of patient residence; county assignment is based on aggregations of zip codes that best approximate county boundaries. Data for Washington State residents hospitalized in Oregon are included, but hospitalizations that occur in other states are not. Emergency department visits that do not result in admission are not reported to CHARS. Data from military hospitals are not included in CHARS.

Rationale: This measure is used in the Report Card and primarily addresses drug and alcohol abuse. There has been a doubling of the poisoning death rates between 1990 and 2004 in Washington State and the majority (70%) of poisoning deaths is unintentional. For unintentional poisoning deaths in 2004 of which there were 626, 1.4% were due to alcohol poisoning, 96.3% were due to drugs (prescription drugs, a combination of prescription and illicit, and illicit and unspecified opioids), and the remaining were due to gases (like carbon monoxide) and other chemicals.

17. Percent of women living in Washington who received prenatal care during 1st trimester

Data: Birth certificates self-reported which can reliability depends on hospitals and if filled out correctly. Limitation is 1/5 of all records are not filled out which resulted in change in 2003. Continue informing hospitals of need for valid/accurate data. DOH staff do visit and LHJs have in past. State has developed website where hospitals can see the reports and what is not filled in so they can increase their level of reporting. Need to look for ways to encourage, reward or incentives.

Rationale: Early and continuous prenatal care has long been seen as an important way to improve the health of mothers and to prevent adverse birth outcomes. Although emerging research is showing that preconception care (care provided even before a woman is pregnant) is **very** important, first trimester prenatal care is still used as the traditional measure.

18. Percent of pregnant women who smoke during 2nd /3rd trimester pregnancy

Data: Birth certificates self-reported which can reliability depends on hospitals and if filled out correctly. Limitation is 1/5 of all records are not filled out which resulted in change in 2003. Continue informing hospitals of need for valid/accurate data. DOH staff do visit and LHJs have in past. State has developed website where hospitals can see the reports and what is not filled in so they can increase their level of reporting. Need to look for ways to encourage, reward or incentives.

Rationale: Tobacco smoking during pregnancy is the most important preventable cause of low birth weight. Smoking is also associated with spontaneous abortion.

19. Birth rate for females 15-17 years

Data: Birth certificates self-reported which can reliability depends on hospitals and if filled out correctly. Limitation is 1/5 of all records are not filled out which resulted in change in 2003. Continue informing hospitals of need for valid/accurate data. DOH staff do visit and LHJs have in past. State has developed website where hospitals can see the reports and what is not filled in so they can increase their level of reporting. Need to look for ways to encourage, reward or incentives.

Rationale: Children of teen mothers are more likely to be born preterm, with a low birth weight and die during their first year of life than children born to women who delay childbearing beyond their teen years.

20. Percent low birth weight rate among singletons (<2500g, 3 yr average)

Data: Birth Certificates self-reported which can reliability depends on hospitals and if filled out correctly. Limitation is 1/5 of all records are not filled out which resulted in change in 2003. Continue informing hospitals of need for valid/accurate data. DOH staff do visit and Local Health Jurisdictions have in past. State has developed website where hospitals can see the reports and what is not filled in so they can increase their level of reporting. Need to look for ways to encourage, reward or incentives. In order to have enough data for small counties, may need to use three year average.

Rationale: Low birth weight (LBW) is a major contributor to infant morbidity and mortality. LBW infants are either those who experience normal growth but are born too early (preterm) or those who are born pre-term or full term, but have inadequate fetal growth (intrauterine growth restriction). A preterm infant is at risk for respiratory, gastrointestinal, immunologic, and neurological problems. Newborns with inadequate fetal growth are prone to birth asphyxia, hypoglycemia, temperature instability, infection, and circulatory problems

21. Percent of 10th graders who report having met recommendations for vigorous physical activity

Data: Healthy Youth Survey. County data are available for most counties. In 2004, for grade 10, there were 10 counties with response rates high enough to assure ability to generalize (response rate of 70% or higher), 21 counties with response rates that should be accompanied by a caution (response rate of 40%-69%), and 8 counties that do not have county level reports posted on the HYS website due to small size or response rates below 40% Best surveying time is 10th grade as high-risk students may drop out of school before grade 12. The subcommittee has agreed to report counties with 40% and greater response rates, accompanied by a data note. Of the counties with at least 70% response rates, only about half also have 95% confidence intervals of no more that $\pm 5\%$ so it may be necessary to combine years (e.g. 2004 and 2006) for small counties. Since participation rates vary from year to year, there will be fewer counties with trend data than data in a particular year. Availability of local data depends on funding levels; funding for county level HYS data is currently provided mainly by the Tobacco Prevention and Control program.

Rationale: Young people who make exercise part of their daily routine will likely continue this behavior into adulthood. Some immediate effects of physical activity include building and maintaining healthy bones and lean muscles, controlling weight, reducing feelings of depression and anxiety, and promoting psychological well-being. Physical activity can lower high blood pressure and cholesterol levels in children. Long-term effects include a reduced risk of death from heart disease and premature death in general and a reduced risk of developing diabetes, colon cancer, and high blood pressure (Centers for Disease Control and Prevention, 1999).

22. Unintentional injury hospitalizations (age 0-17, 3 year average)

This indicator is based on hospital discharge data collected by the Comprehensive Hospital Abstract Reporting System (CHARS). There are no comparable national data. CHARS data are collected by zip code of patient residence; county assignment is based on aggregations of zip codes that best approximate county boundaries. Data for Washington State residents hospitalized in Oregon are included, but hospitalizations that occur in other states are not. Emergency department visits that do not result in admission are not reported to CHARS. Data from military hospitals are not included in CHARS.

Rationale: Unintentional injury is a leading cause of hospitalization and mortality among children age 0-17. This indicator includes hospitalizations from all causes of unintentional injury including motor vehicle crashes, falls, poisoning, drowning, firearms, and others. Local Health Jurisdictions who observe elevated and/or increasing rates of unintentional injury hospitalizations should conduct further analysis to identify the specific causes and risk groups.

23. Asthma hospitalizations (age 0-17, 3 year average)

Data: This indicator is based on hospital discharge data collected by the Comprehensive Hospital Abstract Reporting System (CHARS). There are no comparable national data. CHARS data are collected by zip code of patient residence; county assignment is based on aggregations of zip codes that best approximate county boundaries. Data for Washington State residents hospitalized in Oregon are included, but hospitalizations that occur in other states are not. Emergency department visits that do not result in admission are not reported to CHARS. Data from military hospitals are not included in CHARS.

Rationale: Asthma is the most common childhood chronic illness, causing missed school days, activity limitations, and when not properly managed in an outpatient setting hospitalizations. The risk for asthma hospitalization varies by age, gender, and race. LHJs observing elevated and/or increasing trends in asthma hospitalizations should conduct further analysis to identify groups at risk in their community.

24. Percent of adults in households who report unmet medical needs due to cost

Data: BRFSS question based on weighted number of adults (population estimate) who report unmet medical needs due to cost. It may be necessary to combine several years of data for small counties.

Rationale: While public health influence is not direct, inadequate income or health insurance may result in health concerns not being addressed in a timely or comprehensive manner.

25. Percent of adults who report usual source of health care

Data: BRFSS, question based on weighted number of adults (population estimate) who report a usual source of health care. It may be necessary to combine several years of data for small counties. This indicator does not account for people seeing different providers in clinic settings.

Rationale: When an individual relates to a place or provider of health care (often referred to as a medical home), they are more likely to seek primary health care for routine preventative services, rather than seek more expensive health care services in the hospital emergency room.

26. Percent of adults who report visiting a dentist in the past year

Data: BRFSS question based on weighted number of adults who report a dentist visit in the past year. It may be necessary to combine several years of data for small counties.

Rationale: Maintaining good oral health takes repeated efforts on the part of the individual, caregivers, and health care providers. Daily oral hygiene routines and healthy lifestyle behaviors play an important role in prevention of oral diseases. Regular preventive dental care can reduce the development of disease and facilitate early diagnosis and treatment. HP2010 Objective 21-12 looks at the percentage of people (children and adults) who had their teeth cleaned in the past year. Having one's teeth cleaned by a dentist or dental hygienist is indicative of preventive behaviors.

27a-c. Percent of adults who report receiving preventative cancer screenings (breast, cervical, colorectal) within recommended time frame (3 indicators)

Data: BRFSS. Funding is needed to have this collected each year. It may be necessary to combine several years of data for small counties.

Rationale: Cancer screening is intended to detect cancers at curable stages. It may be necessary to do composite of all three screenings. Target Healthy People 2010 goals: Cervical: 90%, Breast- 70%, Colorectal: 50%.

28. Percent of adults who report having health insurance

Data: BRFSS question which measures health insurance coverage for adults in household.

Rationale: Health Insurance is an important determinant of health and disability status. Health insurance is a critical factor in influencing timely access to health care. Persons without health insurance are less likely to have a regular or usual health provider, less likely to obtain preventive care and routine screenings, or to obtain needed tests and prescriptions. Source: Healthy People 2010.

29. Percent of children who are insured

Data: Subcommittee recommends a new BRFSS question to read: “Do your children have any kind of health care insurance?” Data would be available at the county level every year for age group under 18 years. This data will be used by counties to look at health care access. It may be necessary to combine several years of data for small counties. Note: The WA Population Survey: data source is the only other data source. However this survey data collected every two years is regionalized into 8 regions statewide and is not available by county.

Rationale: In 2004, children represented approximately 16% of the uninsured population and the rate continues to increase as less adults are covered by health insurance. Inadequate income or health insurance may result in unmet medical, dental, and mental health needs. The percent of population living below 200% of poverty was not chosen as part of this set of indicators. However it is noted that for both adults and children, poverty is a key social determinant of health, and the level of poverty (in this case, an indication of the near-poor) in a geographic area has a strong effect on health care access rates and a broad swath of other health indicators.

30. Percent permitted solid waste facilities in compliance with permit conditions

Data: All counties have responsibility for permitting all solid waste facilities, which include things like landfills, transfer stations and composting facilities.

Rationale: Improperly operated facilities can result in vector/vermin problems, and can impact ground and surface water resources. Department of Ecology provides funding.. Not that many facilities are out of compliance e.g. 16 permitted facilities for population of 250,000 in Thurston County in 2006.

31. Percent inspections of permanent food establishments with 35 or more critical violation points

Data: available at local county level. Sampling could be done over time. This data is beginning to be tracked as part of the pilot project.

Rationale: These are the food service establishments that have more than 35 critical violation points when inspected pose the highest risk for causing food borne outbreaks. Critical violations usually involve important food safety items such as proper heating and cooling, cross contamination, hand washing and proper food storage.

32. Percent of Identified On-Site Sewer System Failures initiated with Corrective Action within 2 weeks

Data: All counties keep track of failures identified and corrected. Data is being tracked as part of pilot project.

Rationale: It is important preventive step to correct on-site failures when first detected. The numbers are small, approximately 200 in Thurston Co. for population of 250,000.

IV. Recommendations for Implementation

1. The PHIP Performance Management and Key Health Indicator committees should approve the recommended set of Local Public Health Indicators (listed above) and implement monitoring of each of the indicators at the local jurisdiction level wherever possible, with the full set of local results and aggregate state level results to be reported at least every other year.
2. A systematic data collection and reporting process for the Local Public Health Indicators should be developed and implemented as soon as possible, but no later than mid-2007 to report data every other year at the local jurisdiction level for the most current data available. A data quality subcommittee will be formed to oversee the process.
3. Funding strategies should be developed to support data collection of any Local PHI not currently available at the local jurisdiction level on a population basis for all recommended Local PHI by YE 2007. Depending on the availability of Tobacco Prevention and Control funding, additional funds may be needed to maintain current levels of local data through data collected in the Healthy Youth Survey and the Behavioral Risk Factor Surveillance System survey.
4. The results of monitoring the Local PHI should be reported at the local jurisdiction and state levels in conjunction with the 2008 Performance Assessment and in all future assessment cycles to facilitate external performance reporting and quality improvement activities at local and state levels.
5. Local jurisdictions and DOH should continue monitoring and surveillance functions of other important performance and health indicators that are part of the larger local, county and state health data sets, including data for less frequent, but serious health events and other types of population-based health data.
6. The Local Public Health Indicator set should be reevaluated after the completion of two - 2 year reporting cycles to assure that important, current health status and health determinant indicators are included in the ongoing set of Local Public Health Indicators.
7. The implementation of the Local Public Health Indicators will be in collaboration with:
 - the Performance Management committee to develop a timeline for the roll-out of the indicators coordinated with the revised Standards for Performance,
 - the support and participation of the Key Health Indicator committee members,
 - the Communications committee to assist in clarifying messages,
 - the Workforce Development committee on training public health staff to use the Local Public Health Indicators for decision-making, and
 - other external performance accountability processes.

Attachments

A. PHI Subcommittee Membership

Chair
Lyndia Vold Spokane Regional Health District

Staff	Consultants
Mary Looker DOH/Community and Rural Health	MCPP Healthcare Consulting

Members	
Lillian Bensley DOH/Epidemiology	Mary Ann O'Garro Thurston Co. Public Health and Social Svcs Department
Joan Brewster DOH/Public Health Systems Development	Riley Peters DOH/Maternal and Child Health
Joe Campo DOH/Center for Health Statistics	Marianne Remy Thurston Co. Public Health and Social Svcs Department
Kathy Chapman DOH/Maternal and Child Health	Amy Riffe Spokane Regional Health District
Wayne Clifford DOH/Environmental Health Assessment	Jennifer Sabel DOH/Emergency Medical and Trauma Systems
Harvey Crowder Walla Walla County Health Department	Katrina Wynkoop Simmons DOH/Center for Health Statistics
Marcia Goldoft DOH/Epidemiology	Don Sloma Washington Health Foundation
Vic Harris Tacoma-Pierce County Health Department	Torney Smith Spokane Regional Health District
Lauren Jenks DOH/Community Wellness and Prevention	David Solet Public Health - Seattle and King County
Jessica Johnson Yakima Health District	Christie Spice DOH/Community Assessment
Vicki Kirkpatrick WSALPHO	Art Starry Thurston Co. Public Health and Social Svcs Department
Carrie McLachlan Island County Health Department	Jude Van Buren DOH/Epi, Health Statistics and Public Health Laboratories

Public Health in Washington State Performance Management Glossary

Prepared by
MCPP Healthcare Consulting
8-23-06

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This Glossary has been compiled to assist local and state public health staff, as well as leadership and governance entities, in their work on performance management of the public health enterprise or “system”. This important work will be more effective if there is shared understanding of these words and concepts.

The Glossary is organized by listing key words alphabetically and grouping related concepts under these key words (for example, under Community/Community Involvement there are a series of definitions, grouped conceptually). An Index references the location of specific words.

The source(s) for the definitions are provided. Bracketed comments [] add to or further clarify sourced definitions and/or crosswalk to related key words in the Glossary. Throughout, organizations or agencies are referred to interchangeably, depending on the source. Organizations/agencies are both public and private.

Annual

Evidence that action or activity has occurred within the last 14 months by dated documentation or policy statement of frequency of activity. [12 months plus 2 months grace period]

National Committee for Quality Assurance (NCQA)

Assessment

Collecting, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve public health.

Assessment in Action: Improving Community Health Assessment Practice, Clegg and Associates, 2003.

Community / Community Involvement (and related concepts)

Community is a group of people who have common characteristics: communities can be defined by location, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other common bonds. Ideally, there should be available assets and resources, as well as collective discussion, decision-making and action. [It is assumed that the assets and resources will be available to the community to support collective action.]

Turnock, B. *Public Health: What It Is and How It Works*, Aspen Publishers, 2001

Public is relating to, or affecting all the people or the whole area of a nation or state; relating to, or being in the service of the community or nation; or, devoted to the general or national welfare

Merriam Webster Dictionary

Partners fully share risks, responsibilities, resources, and rewards in collaborative efforts. They establish mutually respectful, trusting relationships, take the time to understand each other's motivations and hoped for accomplishments, and define and address challenges in a manner that provides opportunities for all partners to share in their solutions.

Himmelman, A, *Collaboration For A Change*, Himmelman Consulting, 2004

Stakeholders are all persons, agencies and organizations with an investment or "stake" in the health of the community and the local public health system. This broad definition includes persons and organizations that benefit and/or participate in the delivery of services that promote the public's health and overall well-being. [Partners are included in stakeholders.]

National Public Health Performance Standards, Centers for Disease Control and Prevention, 2004

Coalition is an organized group of people in a community working toward a common goal. The coalition can have individual, group, institutional, community, and public policy goals.

www.edc.org/hec/instruments/glossary.

Cooperation is characterized by informal relationships that exist without any commonly defined mission, structure or planning effort. Information is shared as needed, and authority is retained by each organization so there is virtually no risk. Resources are separate as are rewards.

Collaboration: What makes it work, Amherst G. Wilder Foundation, 1998

Coordination is characterized by more formal relationships and understanding of compatible missions. Some planning and division of roles are required, and communication channels are established. Authority still rests with the individual organizations, but there is some increased risk to all participants. Resources are available to participants and rewards are mutually acknowledged.

Collaboration: What makes it work, Amherst G. Wilder Foundation, 1998

Collaboration is a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. The relationship includes a commitment to mutual relationships and goals; a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards.

Collaboration: What makes it work, Amherst G. Wilder Foundation, 1998

Community Development is defined as
a group of people
in a community
reaching a decision
to initiate a social action process
to change their economic, social, cultural [health] or environmental situation

Christensen, J, Robinson, J,
Community development in America, Iowa State University Press, 1980

Community Mobilization is the act of engaging all sectors of a community in a community-wide prevention effort.

Center for Substance Abuse Prevention's Western Center for the Application of Prevention Technologies

<http://casat.unr.edu/bestpractices>

Asset Mapping, is a tool for mobilizing community resources. It is the process by which the capacities of individuals, civic associations, and local institutions are inventoried.

NACCHO

http://mapp.naccho.org/mapp_glossary.asp

Capacity-building is a strategy to increase the ability of community, neighborhood, and constituency-based organizations to prioritize issues and secure resources relevant for addressing challenges defined and determined by those organizations.

Himmelman, A, *Collaboration For A Change*, Himmelman Consulting, 2004

Compliance

Compliance is defined as conformity in fulfilling official requirements.

Merriam-Webster

Critical Health Services

Health services and health conditions or risks for which appropriate services—screening, education and counseling, or interventions—are needed. [See Appendix A for a detailed listing of the *Critical Health Services*. See the full report on the SBOH website for a discussion of the evidence-based process

Final Report on Access to Critical Health Services, State Board of Health, 2001.

for developing the list:

http://www.doh.wa.gov/SBOH/Pubs/documents/AccessReport_2001.pdf]

Current and/or “Up to Date”

For policies and procedures, *current* requires evidence of review and/or revision within the last two years. For reports or performance audits, the requirement is the most recent data available within the last three years. [Note that this definition is intended to apply to the currency of documents under review, not clinical procedures.]

NCQA

Customer Service

Customer service is defined as providing customers with goods and services that meet their expectations and needs at a price they are willing to pay. [Note that price=cost, which include convenience and time as well as a dollar amount.]

Gitlow, H.S and S.J., *The Deming Guide to Quality and Competitive Position*, Prentice Hall, 1987

Customer service standards are statements adopted by an organization that specify, in behavioral terms, expectations of staff in regard to customer service.

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Evidence-based Practices [EBPs] (and related concepts)

Evidence-based Practices (interventions) are the systematic selection, implementation, and evaluation of strategies, programs and policies with evidence from the scientific literature that they have demonstrated effectiveness in accomplishing intended outcomes. [The Substance Abuse and Mental Health Services Administration, in refining the agency’s National Registry of Evidence-based Programs and Practices, has adopted a multidimensional approach to rating programs and practices. The dimensions include Descriptive (e.g., effects and impact, relevant populations and settings), Strength of Evidence (e.g., research design, reliability), and Readiness for Dissemination (e.g., materials, training and support).]

American Journal of Health Education, 2001

Evidence-based *practices* are skills, techniques, and strategies that can be used by a practitioner. Evidence-based *programs* consist of collections of practices that are done within known parameters (philosophy, values, service delivery structure, and treatment components) and with accountability to the consumers and funders of those practices.

Implementation Research: A Synthesis of the Literature, University of South Florida, 2005

Best practices are the best clinical or administrative practice or approach at the moment, given the situation, the consumer’s or family’s needs and desires, the evidence about what works for this situation/need/desire, and the resources available.

Turning Knowledge into Practice, ACMHA, 2003

Promising practices are clinical or administrative practices for which there is considerable evidence or expert consensus and which show promise in improving client outcomes, but which are not yet proven by the highest or strongest scientific evidence.

Turning Knowledge into Practice, ACMHA, 2003

Government Management, Accountability, and Performance (GMAP)

GMAP is the process being used to support implementation of smart performance management practices across the enterprise of state government. Components include: using logic models to illustrate how an agency's activities and programs convert resources to outputs and various levels of outcomes; building a portfolio of measures; collecting data; data analysis; using data and statistical analysis tools to analyze and improve performance; using non-statistical tools to analyze and improve performance; budgeting for performance; using charts and graphs to communicate about performance; leading for results; presenting information to decision makers; writing in plain talk; and reporting performance to citizens and stakeholders.

GMAP Curriculum Draft 6/26/05.

Health Data (and related concepts)

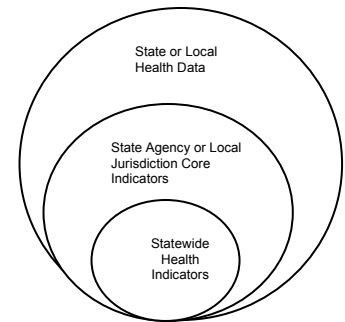
Health data include community health status (gathered through birth and death certificates, hospital discharge diagnoses, statewide and local surveys, other epidemiologic sources), communicable disease (food/water/air/waste/vector borne), environmental health risks, presence of and use of healthcare facilities and providers, preventive services, and other information identified by the community as helpful for planning. [See also *Performance Management and Program Planning and Evaluation*]

Core indicators are a subset of health data. They are data sets established by state or local agencies that are tracked over time and reported publicly, and include selected health status information, communicable disease and environmental health risks and related illnesses. These data sets are likely to differ among local jurisdictions as well as between the state agency and local jurisdictions, reflecting variations in priorities and community areas of focus. [Program Evaluation data may contribute to this data set.]

Statewide Health Indicators are a subset of state and local health data and either a companion set or subset of state or local core indicators. These data sets have been selected for use statewide, to be reported by DOH on a consistent basis for all LHJs as well as statewide. Whenever possible, they are accompanied by benchmark data from other LHJs, other states, and/or national data. [Program Evaluation data may contribute to this data set.]

Health Status Indicators measure the current state of a specific aspect of health.

Health Determinants include measures relating to social and economic environment, the physical environment, and the person's individual characteristics and behaviors all of which affect health status over time



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Health Indicators Subcommittee

World Health Organization

Quantitative data are measurement variables or data that can be measured and represented on a numerical scale, such as number of services, annual revenue, and number of employees.

Mendenhall, William; *Statistics for Management and Economics*; 1978

Quantitative analysis is an analysis of findings that must include a first-level, quantitative data analysis that incorporates aggregate results and trends over time. The analysis must include a comparison of results against a standard or goal, if one was set.

2004 MCO Standards and Guidelines, NCQA, 2003

Qualitative data are attribute variables or data that cannot be measured and are not necessarily represented in numerical form, such as results from focus groups or interviews with individuals.

Mendenhall, William; *Statistics for Management and Economics*; 1978

Qualitative analysis is a root cause analysis or barrier analysis to identify the reasons for the results. [Includes non-numerical analytic tools such as fishbone diagrams.] This is especially important when results do not meet the goal set by the organization. [Results being the *Quantitative Analysis* described above.]

2004 MCO Standards and Guidelines, NCQA, 2003

Numerator and Denominator. The word "numerator" is related to the word "enumerate." To enumerate means to "tell how many"; thus the numerator tells us how many fractional parts we have in the indicated fraction. To denominate means to "give a name" or "tell what kind"; thus the denominator tells us what kind of parts we have. [Used to calculate a rate or percentage: X (numerator) of all (denominator).]

www.brainyencyclopedia.com

Gap analysis is the assessment of the gap between stated goals and current reality. If there were no gap, there would be no need for any action to move toward goals.

Senge, Peter, *The Fifth Discipline*, Doubleday, 1990

Health Disparities

Health Disparities refer to differences in populations' health status that are avoidable and can be changed. These differences can result from [environmental], social and/or economic conditions, as well as public policy. These and other factors adversely affect population health.

Operational Definition of a Functional Local Health Department. NACCHO, November 2005.

Health Provider

Health Care Provider is a person, agency, department, unit, subcontractor, or other entity that delivers a health-related service, whether for payment or as an employee of a governmental or other entity. Examples include hospitals, clinics, free clinics, community health centers, private practitioners, and the local health department. [See also *Notifiable Conditions*.]

NACCHO

http://mapp.naccho.org/mapp_glossary.asp

Internal Audit

The process of reviewing a sample of case write-ups or case files completed by individuals conducting investigation or compliance activities, to determine if the activity is being done in a timely, accurate and comprehensive manner and follows established protocols or procedures. For example, on an annual basis, the documented review of 30 write-ups of communicable disease investigations or food establishment inspections for a specific staff person. The review should include performance on specific requirements and identification of activities needing improvement, if any.

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Local Health Jurisdiction (LHJ)

Washington has 35 [local health departments/districts](http://www.doh.wa.gov/about.htm) [collectively known as local health jurisdictions]. They are local government agencies, not satellite offices of the state Department of Health or the State Board of Health. Local health departments carry out a wide variety of programs to promote health, help prevent disease and build healthy communities.

www.doh.wa.gov/about.htm

Meaningful Improvement in Public Health (and related concepts)

Quality refers to the appropriateness of performed public health services and other organizational activities in relation to their stated goals and standards of practice. It focuses on the process of service delivery and department functioning.

Effectiveness is the extent to which a public health service, activity, or intervention achieves its intended effect. The effectiveness domain focuses on the outcomes of services and department functioning.

Efficiency is the ratio of the amount of resources consumers (inputs such as staff hours, administrative costs, supplies, etc) to the client outcomes observed or the quantity of services performed. As such, efficiency may be measured relative to aspects of quality (i.e., to health services performed) or relative to effectiveness (i.e., to health benefits produced)

Accessibility is the extent to which a public health service is readily available to the community's individuals in need. The accessibility domain refers to the capacity of the agency to provide service in such a way as to reflect and honor the social and cultural characteristics of the community and focuses on agency efforts to reduce barriers to service utilization. [Includes physical accessibility.]

Reedy AM, Luna RG, Olivas GS and Sujeer A. *Local Public Health Performance Measurement: Implementation Strategies and Lessons Learned From Aligning Program Evaluation Indicators with the 10 Essential Public Health Services*. Journal of Public Health Management Practice, 2005 11(4) 317-325.

Medical Home

A *medical home* is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A *medical home* is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.

American Academy of Pediatrics,
www.medicalhomeinfo.org/

Monitoring

Monitoring is used in the *Standards for Public Health in Washington State* as a more public-friendly way of describing public health surveillance activity.

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Surveillance is systematic monitoring of the health status of a population.

Turnock, B. *Public Health: What It Is and How It Works*, Aspen Publishers, 2001

Notifiable Conditions

Notifiable conditions are the legal requirements for disease reporting that form the foundation for disease surveillance and require health care providers, health care facilities, laboratories, veterinarians, food service establishments, child day care facilities, and schools to notify public health authorities of suspected or confirmed cases of selected diseases or conditions.

Washington State Department of Health

www.doh.wa.gov/Notify/

Outbreak

An *outbreak* is the occurrence of more cases of disease than would normally be expected in a specific place or group of people over a given period of time.

Centers for Disease Control and Prevention

www.cdc.gov/EXCITE/classroom

Performance Management / Measurement

Performance measure is the specific quantitative representation of capacity, process, or outcome deemed relevant to the assessment of performance. [See also *Government Management, Accountability, and Performance (GMAP)* and *Program Planning and Evaluation*.]

Lichiello, P. *Turning Point Guidebook for Performance Measurement*, Turning Point National Program Office, December 1999.

Performance measurement is the regular collection and reporting of data to track work produced and results achieved. Performance measurement analyzes the success of an organization's efforts by comparing data on what actually happened to what was planned or intended. [See also *Program Planning and Evaluation* and *Quality Improvement*.]

Performance management is the use of performance measurement information to help set agreed-upon performance goals, allocate and prioritize resources, inform managers to either confirm or change current policy or program directions to meet those goals, and report on the success in meeting those goals. [See also *Program Planning and Evaluation*, *Strategic Planning*, and *Quality Improvement* in this Glossary as well as the *Performance Management Maps*.]

Policy Development

Policy development contributes to the development of formal policies (e.g., legislation, regulations, and ordinances, [budget]) and informal policies (e.g., worksite, community and family norms that support healthy communities.) Includes policy implementation, evaluation, and community mobilization.

Spokane Regional Health District

Prevention (and related concepts)

Primary Prevention consists of strategies that seek to prevent the occurrence of disease or injury, generally through reducing exposure or risk factor levels. These strategies can reduce or eliminate causative risk factors (risk reduction). [Also referred to as Universal Prevention.]

Turnock, B. *Public Health: What It Is and How It Works*, Aspen Publishers, 2001

Secondary Prevention consists of strategies that seek to identify and control disease processes in their early stages before signs and symptoms develop (screening and treatment). [Also Referred to as Selective Prevention.]

Turnock, B. *Public Health: What It Is and How It Works*, Aspen Publishers, 2001

Tertiary Prevention consists of strategies that prevent disability by restoring individuals to their optimal level of functioning after a disease or injury is established and damage is done. [Also referred to as Indicated Prevention.]

Turnock, B. *Public Health: What It Is and How It Works*, Aspen Publishers, 2001

Health Promotion is an intervention strategy that seeks to eliminate or reduce exposures to harmful factors by modifying human behaviors. Any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental adaptations that will improve or protect health. This process enables individuals and communities to control and improve their own health. Health promotion approaches provide opportunities for people to identify problems, develop solutions, and work in partnerships that build on existing skills and strengths. [Most often used as a *Primary Prevention* strategy.]

Turnock, B. *Public Health: What It Is and How It Works*, Aspen Publishers, 2001

Health Education is any combination of learning opportunities designed to facilitate voluntary adaptations of behavior (in individuals, groups, or communities) conducive to good health. Health education encourages positive health behavior. [May be used for *Primary*, *Secondary*, and *Tertiary Prevention* as well as being a tool for *Health Promotion*.]

Turnock, B. *Public Health: What It Is and How It Works*, Aspen Publishers, 2001

Program (and related concepts)

For the purpose of *Performance Management*, *Program* is used broadly to refer to any activity that is provided or overseen by the state or local public health entity in support of the mission of *Public Health*.

Program is used to identify the unit of analysis or the target of evaluation. It encompasses the wide variety of services a department provides, including direct services, community mobilization, policy development, laboratory services, enforcement activities, and [or] any other activities that have distinct goals and objectives and are implemented to

Reedy AM, Luna RG, Olivas GS and Sujeer A. *Local Public Health Performance Measurement*:

accomplish the mission of the department.

Program is a coherent set of clearly described activities and specified linkages among activities designed to produce a set of desired outcomes.

Implementation Research: A Synthesis of the Literature, University of South Florida, 2005

Activities are specific interventions and related services that are intended to change outcomes. [May also be called strategies; these are programmatic strategies as distinct from organizational strategies, as defined in *Strategic Planning*.]

Organizational Research Services

Program Planning and Evaluation (and related concepts)

See also *Strategic Planning* and *Quality Improvement*. Generally, *Strategic Planning* and *Quality Improvement* occur at the level of the overall organization, while *Program Planning and Evaluation* are program specific activities that feed into the *Strategic Plan* and into *Quality Improvement*. *Program Evaluation* alone does not equate with *Quality Improvement* unless program evaluation data are used to design program improvements and to measure the results of the improvements as implemented.

The *Strategic Plan* focuses on a range of organizational goals, strategies and objectives including new initiatives, while the *Quality Plan* identifies specific areas of current operational performance for improvement.

Definitions below are from the program planning and evaluation approach and from the logic model approach. The bracketed comments describe the relationships between these two program development methods, both commonly in use in public health.

Program evaluation is defined as the systematic application of social [or scientific] research procedures for assessing the conceptualization, design, implementation, and utility of social [community] intervention programs.

Rossi PH, Freeman HE, Lipsey MW. *Evaluation: A Systematic Approach*. 6th ed. Sage; 1999.

Goals are general statements expressing a program's aspirations or intended effect on one or more health problems, often stated without time limits

Turnock, B. *Public Health: What It Is and How It Works*, Aspen Publishers, 2001

Objectives are targets for achievement through interventions. Objectives are time-limited and measurable in all cases. Various levels of objectives for an intervention include outcome, impact and process objectives.

Turnock, B. *Public Health: What It Is and How It Works*, Aspen Publishers, 2001

Outcomes [program planning approach] are sometimes referred to as results of the health system; these are indicators of health status, risk reduction, and quality-of-life enhancement. Outcomes are long-term objectives that define optimal, measurable future levels of health status; maximum acceptable levels of disease, injury, or dysfunction; or prevalence of risk factors. [Note also the way in which outcomes are defined by the *Logic Model* and the bracketed comments relating the two planning methods and their use of terms.]

Turnock, B. *Public Health: What It Is and How It Works*, Aspen Publishers, 2001

Logic model is a systematic and visual way to present and share an understanding of the relationships among the resources available to operate a program, the activities planned, and the changes or results expected to be achieved.

Logic Model Development Guide, W.K. Kellogg Foundation, 2004

Outputs are data about activities. They are the direct results of program activities, usually described in terms of size and scope of the services or products delivered or produced by the program. They indicate whether or not a program was delivered to the intended audiences at the intended “dose”. A program output, for example, might include the number of classes taught, meetings held, materials distributed, program participation rates, or total service delivery hours. [In program planning terms, the *Outputs* are process *Objectives* and their *Performance Measures*.]

Logic Model Development Guide, W.K. Kellogg Foundation, 2004

Outcomes [logic model approach] are the specific changes in program participants’ [or populations, communities, organizations, systems] behavior, knowledge, skills, status and level of functioning. Short-term outcomes should be attainable within 1-3 years, while longer-term outcomes should be achievable within a 4-6 year timeframe. [In program planning terms, the *Outcomes* are either outcome or impact *Objectives* and their *Performance Measures* (also referred to generically as *Outcomes*).]

Logic Model Development Guide, W.K. Kellogg Foundation, 2004

Indicators are specific measurable and observable changes that can be “seen, heard or read” to demonstrate that an outcome is being met. [Note that there is overlapping usage among *Indicators*, *Outcomes*, *Outputs*, and *Performance Measures*.]

Organizational Research Services

Impact is the fundamental intended or unintended change occurring in organizations, communities or systems as a result of program activities within 7-10 years. [In program planning terms, the *Impact* is the *Goal* of the program.]

Logic Model Development Guide, W.K. Kellogg Foundation, 2004

SMART criteria for developing program measures include:

- Specific
- Measurable
- Attributable [and Actionable]
- Relevant
- Timebound

We Can’t Measure What We Do, GMAP training presentation, Campbell, M.

Protocol or Procedure

A written description of the step-by-step actions and decisions an individual or organization must complete in performing a specific activity or service.

MCPP Healthcare Consulting

Public Health (and related concepts)

Public Health includes the activities that society undertakes to assure the conditions in which people can be healthy. These include organized community efforts to prevent, identify and counter threats to the health of the public.

Turnock, B. *Public Health: What It Is and How It Works*, Aspen Publishers, 2001

Local *Public Health System* is the human, informational, financial, and organizational resources, including public, private, and voluntary organizations and individuals, that contribute to the public's health.

NACCHO

http://mapp.naccho.org/mapp_glossary.asp

The Three Core Functions and Ten Essential Services of Public Health

Institute of Medicine, *The Future of Public Health*, 1988.

Assessment

Public Health Functions Steering Committee, 1994.

Monitor health status of the community

Diagnose and investigate health problems and hazards

Inform and educate people about health issues

Policy Development

Mobilize partnerships to solve community problems

Support policies and plans to achieve health goals

Assurance

Enforce laws and regulations to achieve health goals

Link people to needed personal health services

Ensure a skilled public health workforce

Evaluate effectiveness, accessibility, and quality of health services

Research and apply innovative solutions

Quality Improvement (and related concepts)

See also *Strategic Planning* and *Program Planning and Evaluation*. Generally, *Strategic Planning* and *Quality Improvement* occur at the level of the overall organization, while *Program Planning and Evaluation* are program specific activities that feed into the *Strategic Plan* and into *Quality Improvement*. *Program Evaluation* alone does not equate with *Quality Improvement* unless program evaluation data are used to design program improvements and to measure the results of the improvements as implemented.

The *Strategic Plan* focuses on a range of organizational goals, strategies and objectives including new initiatives, while the *Quality Plan* identifies specific areas of current operational performance for improvement.

Quality improvement (QI) is an integrative process that links knowledge, structures, processes and outcomes to enhance quality throughout an organization. The intent is to improve the level of performance of key processes and outcomes within an organization.

Standards for Accreditation of Managed Behavioral Healthcare Organizations. National Committee for Quality Assurance.

Quality Plan is a written description of QI activities that has been approved by the governing body and includes an annual plan that describes with timelines, the specific planned activities to be carried out. It should be broad in scope, reflecting a range of health and service issues relevant to the population served.

Standards for Accreditation of Managed Behavioral Healthcare Organizations. National Committee for Quality Assurance.

Quality methods build on an assessment component in which a group of selected indicators [selected by an agency] are regularly tracked and reported. The data should be regularly analyzed through the use of control charts and comparison charts. The indicators show whether or not agency goals and objectives are being achieved and can be used to identify opportunities for improvement. Once selected for improvement, the agency develops and implements interventions, and re-measures to determine if interventions were effective. [These quality methods are frequently summarized at a high level as the Plan/Do/Check/Act (PDCA) or Shewhart Cycle.]

Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), NCQA

Risk Communication

Risk Communication is an interactive process of sharing knowledge and understanding so as to arrive at well-informed risk management decisions. The goal is a better understanding by experts and non-experts alike of the actual and perceived risks, the possible solutions, and the related issues and concerns.

NACCHO

http://mapp.naccho.org/mapp_glossary.asp

Standards for Public Health in Washington State

MCPH Healthcare Consulting

The *Standards* cover key aspects of public health, selected because they represent protection that should be in place everywhere:

- Understanding health issues
- Protecting people from disease
- Responding to public health emergencies
- Promoting healthy living
- Helping people get the healthcare services they need

There are 12 standard areas, each with a varying number of measures for local health jurisdictions and for the state level agency:

- Community Health Assessment
- Communication to the Public and Key Stakeholders
- Community Involvement
- Monitoring and Reporting Threats to the Public's Health
- Planning For and Responding to Public Health Emergencies
- Prevention and Education
- Helping Communities Address Gaps in Critical Health

- Services
- Program Planning and Evaluation
- Fiscal and Management Systems
- . Human Resource Systems
- . Information Systems
- . Leadership and Governance

Strategic Planning (and related concepts)

See also *Quality Improvement* and *Program Planning and Evaluation*. Generally, *Strategic Planning* and *Quality Improvement* occur at the level of the overall organization, while *Program Planning and Evaluation* are program specific activities that feed into the *Strategic Plan* and into *Quality Improvement*. *Program Evaluation* alone does not equate with *Quality Improvement* unless program evaluation data are used to design program improvements and to measure the results of the improvements as implemented.

The *Strategic Plan* focuses on a range of organizational goals, strategies and objectives including new initiatives, while the *Quality Plan* identifies specific areas of current operational performance for improvement.

Strategic Planning is a disciplined process aimed at producing fundamental decisions and actions that will shape and guide what an organization is, what it does, and why it does what it does. The process of assessing a changing environment to create a vision of the future; determining how the organization fits into the anticipated environment, based on its mission, strengths, and weaknesses; then setting in motion a plan of action to position the organization.

Turnock, B. *Public Health: What It Is and How It Works*, Aspen Publishers, 2001

Vision is a statement of the agency’s goals—why it does what it does and what it hopes to achieve.

Multiple sources

Mission is a statement of what the agency does, who it serves, what geographic area it serves.

Multiple sources

Values (and principles) describe how the work is done, what beliefs are held in common as the basis for the work.

Multiple sources

Strategies or strategic goals are broad, long-term [organizational] aims that define a desired result associated with identified strategic issues. [An organizational strategy is often supported by multiple *Objectives*, with specific *Performance Measures*, intended to assist in achievement of the *Strategic Goal*.]

National Public Health Performance Standards, Centers for Disease Control and Prevention, 2004

Priorities merit attention before competing alternatives. [Priority setting occurs in the *Strategic Planning* process when the organization is faced with competing *Strategies* and *Objectives*, and in light of expected resources, must choose which *Strategies* and *Objectives* to pursue.]

Merriam-Webster

Technical Assistance / Consultation

Technical assistance / consultation activities focus on content, methods and tools for program planning, implementation and evaluation, and do not include contract oversight or compliance activities.

MCPP Healthcare Consulting

Training/Training Documentation

Training includes formally structured courses (e.g., classroom, conference, electronic) as well as substantive review of pertinent content as part of a regularly scheduled meeting (e.g., use of written materials, allocation of no less than one hour of time,).

MCPP Healthcare Consulting

Training documentation includes evidence of the content of the training activity in sufficient detail to verify that required topic(s) are included (e.g., annotated agendas, course descriptions, and materials such as powerpoints, web-based course content) and documentation of an individual's participation (e.g., meeting attendance roster, class roster, CE tracking logs, certificates of completion).

Washington State Board of Health

The 10-member [Board of Health](#) provides a citizen forum for the development of public health policy. It recommends strategies and promotes health goals to the Legislature and regulates a number of health activities including drinking water, immunizations, and food handling. The Board is housed with the Department of Health although it is an independent entity.

www.doh.wa.gov/about.htm

Washington State Department of Health

The Department of Health was formed in 1989 to promote and protect public health, monitor health care costs, maintain standards for quality health care delivery, and plan activities related to the health of Washington citizens. The [Secretary of Health](#) is appointed by the governor. The statutory authority for the Department of Health is in the [Revised Code of Washington 43.70.020](#).

www.doh.wa.gov/about.htm

C. Local PHI Criteria Matrix

PHI/PM Subcommittee Final List of PHI Indicators 12/13/06

Potential PHI Indicators	Data Availability			Data Source (eg BRFSS, etc.)	Population Based	Important Aspect Hi/Med/Low	Measurable	Actionable Contr/Influ	Measure HS/HD	Trend Data	Links to Other Indicators	Demographic	Understandable	Comments/Data Validity	Used in WA RC
	NTL	ST	CO												
1. Rate of Reported Chlamydia Infections(women 15-24 yrs)	Y	Y	Y	CFH	Y	M	Y	I	HS	Y	Y	Y	Y	2004 - 1 county 0, 1 county 3, others >5 cases	
2. % Reported adequate Chlamydia treatment for females 15-24 years	N	Y	Y	CFH	Y	M	Y	I	HD	Y	Y	Y	Y	poor compliance with reporting	
3. Influenza vaccine during previous year for 65+ yrs	Y	Y	Y	BRFSS	Y	M	Y	I	HD	Y	N	Y	Y	maybe expand BRFSS ?	
4. Childhood immunization - % of Medicaid (Healthy Options) children who are adequately immunized by two year of age	Y	N	N	CFH	N	H	Y	I	HD	N	N	Y	Y	representative of Medicaid population. Child Profile is desired data source once increased use	
5. Expected years of healthy life at age 20	Y	Y	Y	BRFSS, VS	Y	H	Y	I	HS	Y	Y	Y	Y		WA RC
6. % 10th graders who report smoking in last 30 days	Y	Y	Y	HYS	Y	H	Y	I	HD	Y	Y	Y	Y	HP 2010 16-17c (different grades)	WA RC
7. % of adults who report meeting moderate or vigorous physical activity	Y	Y	Y	BRFSS	Y	H	Y	I	HD	Y	Y	Y	Y		WA RC

8. % of adults who report binge drinking on one or more occasion in past 30 days	Y	Y	Y	BRFSS	Y	M	Y	I	HD	Y	Y	Y	Y		WA RC
9. % of adults who report smoking everyday or some days	Y	Y	Y	BRFSS	Y	H	Y	I	HD	Y	HP2010	Y	Y		WA RC
10. % of adults who are obese & overweight -BMI	Y	Y	Y	BRFSS	Y	H	Y	I	HS	Y	Y	Y	Y	w/ caution (accuracy questionable), w/ definition of calculation	WA RC
11. % adults who report diagnosis of diabetes	Y	Y	Y	BRFSS	Y	H	Y	I	HS	Y	Y	Y	Y		
12. % adults who report 14 or more days of poor mental health in past month	Y	Y	Y	BRFSS	Y	H	Y	I	HS	Y	Y	Y	Y	Low #'s for adults for some counties	WA RC
13. % 10th graders who report alcohol consumption in past 30 days	Y	Y	Y	HYS	Y	M	Y	I	HD	Y	Y	Y	Y	HP 2010 16-17a (different grades)	WA RC
14. % of 10th graders who are overweight -BMI	Y	Y	Y	HYS	Y	H	Y	I	HD	N	Y	Y	Y		WA RC
15. % of adults who report eating fruits and vegetables 5 or > times per day	Y	Y	Y	BRFSS	Y	H	Y	I	HD	Y	Y	Y	Y	Does not use serving size	WA RC
16. Unintentional poisoning hospital rates per 100,000 (all ages)	Y	Y	Y	CHARS	Y	H	Y	I	HD	Y	Y	Y	Y	Includes WA residents hospitalized in Ore but not in other states, does not include military data	WA RC
17. % of women living in WA who received prenatal care during 1st trimester	Y	Y	Y	Vital Records	Y	high	Y	I	HD	yes - after 2003	HP 2010 - 16-6a	Y	Y	> 20% unknowns.	

18. % of pregnant women who smoke during 2nd /3rd trimester pregnancy	Y	Y	Y	Vital Records	Y	high	Y	I	HS	yes - after 2003	HP 2010 - 16-17c	Y	Y	PRAMS data was used for RC on smoking in 3rd trimester.	WA RC
19. Birth rate for females (age 15-17)	Y	Y	Y	Vital Records	Y	high	Y	I	HD	Y	HP 2010	Y	Y		
20. % Low Birth Weight rate among singletons (<2500g, 3 yr average)	Y	Y	Y	Vital Records	Y	high	Y	I	HD	Y	HP 2010 - 16-10a	Y	Y		
21. % 10th graders who report having met recommendations for vigorous physical activity.	Y	Y	Y	HYS	Y	high	Y	I	HD	Y	HP 2010 22-7 (grade 9)	Y	Y		WA RC
22. Unintentional injury hospitalizations (age 0-17, 3 year average)	?	Y	Y	CHARS	Y	high	Y	I	HS	Y	HP 2010 - cause specific	N	Y	Some data for border counties & military hospitals.	
23. Asthma hospitalizations (age 0-17, 3 year average)	?	Y	Y	CHARS	Y	med	Y	I	HS	Y	HP 2010 1-9a	N	Y	May switch to hospitalization for ambulatory care sensitive conditions. Unable to report border counties and counties with major military hospitals.	
24. % of adults in households who report unmet medical need due to cost	Y	Y	Y	BRFSS	Y	Y	Y	I	HD	Y	Y	Y	Y	data even yrs	
25 % of adults who report usual source of health care	N	2005	Y	BRFSS	Y	Y	Y	I	HD	Y	Y	Y	Y		
26. % of adults who report having visited dentist in past year	Y	Y	Y	BRFSS	Y	Y	Y	I	HD	Y	Y	Y	Y		
27. % of adults who report receiving preventative cancer screenings-A. breast, B. cervical, C. colorectal	N	Y	Y	BRFSS	Y	Y	Y	I	HD	Y	Y	Y	Y		

28. % of adults who report having health insurance	N	state	Y	BRFSS	Y	Y	Y	I	HD	Y	Y	Y	Y		
29. % children who are reported as having insurance	N	state	Y	BRFSS	Y	Y	Y	I	HD	Y	Y	Y	Y	recommended new question for 2007	
30. % Permitted solid waste facilities in compliance with permit conditions	N	Y	Y	Ecology	N	M-H	Y	C	HD	Y	Y	N	Y		
31. % inspections of permanent food establishments with 35 or more CV points	N	Y	Y	DOH/local N	N	H	Y	C	HD	Y	Y	N	Y		
32. % Identified on-site sewage system failures initiated w/corrective action w/in 2 wks	N	Y	Y	DOH/local N	N	H	Y	C	HD	Y	Y	N	Y	pilot study is collecting this data	