

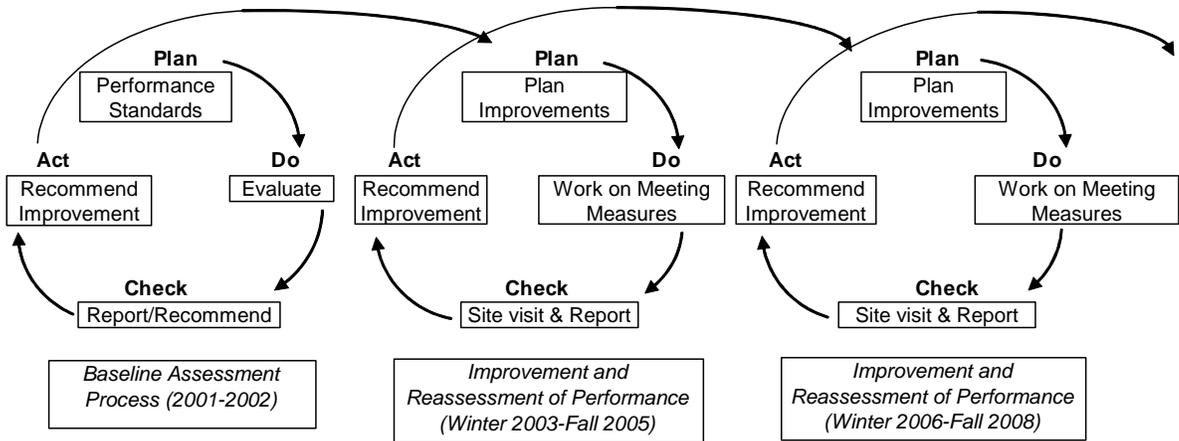
Executive Summary

The Standards

The Standards for Public Health in Washington State were developed in the late 1990s through a collaborative effort between state and local health officials. The first version of the performance standards were adopted in June 2001. In 2002, the public health system performance was measured for the first time in the Baseline Evaluation. This report summarizes the 2005 Assessment of Performance, the re-measurement of performance of Washington State local health jurisdictions and Department of Health programs.

The Standards development and measurement process itself uses the Shewhart Quality Improvement cycle: the Performance Standards are the *Plan* step; the improvement activities are the *Do* step; the site visits, data analysis and this report are the *Check* step; and the future work on system improvement and revision of the standards will be the *Act* step. Application of this PDCA improvement cycle in the public health work processes and programs is critically important in taking action on the performance assessment results for improving public health services and outcomes. This operational improvement cycle is the responsibility of state and local level public health leadership.

The following diagram describes the 2002 Baseline Evaluation cycle, the intervening operational improvement cycle and the current 2005 re-measurement of performance cycle, and the next three year cycle of improvements and re-measurement.



The Performance Assessment Process

The 2005 Assessment of Performance included all 35 local health jurisdictions (LHJs) in the state and 26 Department of Health (DOH) program sites selected by DOH for evaluation. Each site was asked to complete a Self-Assessment Guide to prepare for the on-site evaluation by organizing the documentation that demonstrated performance in the standards and measures.

For this cycle of assessment there were two new aspects that were not part of the 2002 Baseline Evaluation; the selection of specific environmental health and prevention and health promotion programs for more in-depth review, and the evaluation of the new Proposed Administrative Standards. This expansion of the scope of the assessment was addressed through the training and use of internal DOH and LHJ reviewers working under the supervision of the external consultants.

During the site review, an independent consultant and an internal reviewer evaluated the documents and scored each measure. When the reviewer had questions regarding the documentation, an informal interview was conducted with the appropriate staff person. In addition, potential exemplary practice documentation was requested from each site. The on-site reviews 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. This “snapshot” of the system was conducted in LHJs during April and May 2005 and in DOH programs during April and July 2005.

All of the information has been compiled into this system-wide report, with recommendations regarding the next steps for improving the system and for the ongoing measurement cycle. A system-wide Programs Report contains the results of the aggregate LHJ and individual state program results for each program. The Proposed Administrative Standards evaluation findings are in a separate report. Improvement to these findings is already underway, based on the learning in preparing for the site reviews and in the closing conferences.

Overall Findings

Current Statewide Performance

It was clear to the site reviewers that, in the two and a half year period between the 2002 Baseline Evaluation and this 2005 Assessment of Performance, improvements have been developed and implemented in DOH programs and LHJs. Major findings regarding overall system performance include:

- The system works as well as it does because of the skills and commitment of the staff and the scope and depth of work being done to improve the health status of Washington State residents.
- The strengths of the system are tied to investments that have been made over the last ten years, including: local capacity development funds, which have been used for focused efforts within LHJs; the implementation of the communicable disease database Public Health Issues Management System (PHIMS), the recent focus on emergency response planning, and a focus on developing capacity for assessing community health status and reporting within DOH and LHJs.
- DOH programs increased their demonstrated performance in all five topic areas between 2002 and 2005, and have average percent demonstrated in more than 50% of DOH programs in all topic areas.

- Aggregate LHJ results show increased demonstrated performance between 2002 and 2005 in four topic areas, Assessment, Communicable Disease, Environmental Health and Access.
- The average percent of LHJs able to demonstrate performance in the Prevention and Health Promotion topic area decreased from 58% in 2002 to 48% in 2005. Based on the extensive amount of documentation presented from the Tobacco Program in 2002, we believe this lower level of demonstrated performance is partially due to the “Non-Tobacco” effect since the Tobacco program was not able to be used for the program review measures.
- LHJ results show an increased range of overall demonstrated performance in 2005 with 86% to 21% of measures demonstrated (2002 range was 81-25%). Mean demonstrated performance was 55% of all LHJ measures in 2005 compared to 53% in 2002, and median demonstrated performance was 57% compared to 52.5% in 2002.
- In comparisons of percent of change from 2002, one LHJ increased in measures demonstrated by 146%, while there was also a 53% decrease in one LHJ.
- Twenty-one LHJs increased their percent demonstrated, and 11 decreased in percent demonstrated (2 LHJs were not scored in 2002, so no comparisons are available).
- All eight LHJs with budgets of 7.5 million or more demonstrated 60% or more of the measures, which again confirms a budget level of \$7.5 million or more is predictive of being in the group of LHJs that demonstrated higher performance. This is the same finding as in 2002.
- However, of the group of 14 LHJs demonstrating performance on more than 60% of the measures, 43% (6 LHJs) were LHJs with budgets of \$2.5 million or less. This is double the number of LHJs with smaller budgets demonstrating this level of performance in 2002. This indicates variability among LHJs that is not connected to budget or size. Some small town/rural LHJs demonstrated higher overall performance than some urban LHJs.
- This variability in performance indicates that performance, while connected to budget and size, also has other drivers. Field observation suggests these may include:
 - Local leadership and priority setting as demonstrated by the development of strategic plans linked to the standards, tied to performance data;
 - Local funding levels as demonstrated by focused use of LCDF funding 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, use of data as part of community planning efforts.

- Another important correlation shown in the scatter diagram below is the strong relationship between demonstrated performance in the Assessment topic area and overall LHJ demonstrated performance. A 1.00 correlation is considered the strongest and most direct correlation. The Assessment to overall performance correlation is 0.92 and is significant.

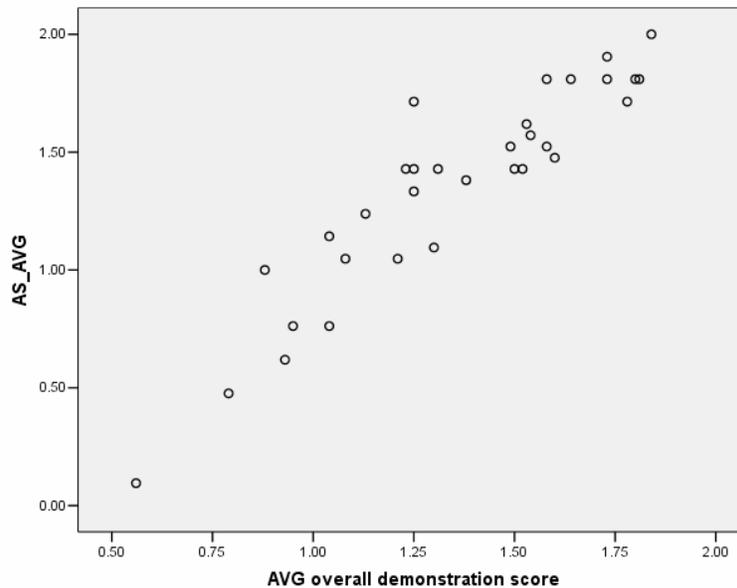


Chart 1: Correlation Between Performance on Assessment Topic Area and Overall Performance

Findings Specific to the Standards and Their Measures

The Standards for Public Health in Washington State are organized into five topic areas. Within each of the topic areas, four to five standards are identified for the whole public health system. For each standard, specific measures are described for local health jurisdictions and, separately, for the state Department of Health and its programs. It is important to remember that the topic areas are not synonymous with programs. For example, all of the measures that address public information and media relations are found under the Communicable Disease topic area, but are applicable across the system; similarly, all of the measures related to emergency planning and response are found under the Environmental Health topic area, but are applicable across the system.

Findings are reported separately for LHJs and state programs and summarized in the topic area charts at the end of this executive summary. Charts that show measure level performance for each Standard are found in Attachments D and E of the full report.

In the summary analysis that follows, there is a focus on the 50th percentile, in which the midpoint is envisioned as a fulcrum: where the weight falls toward demonstrated performance, 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.

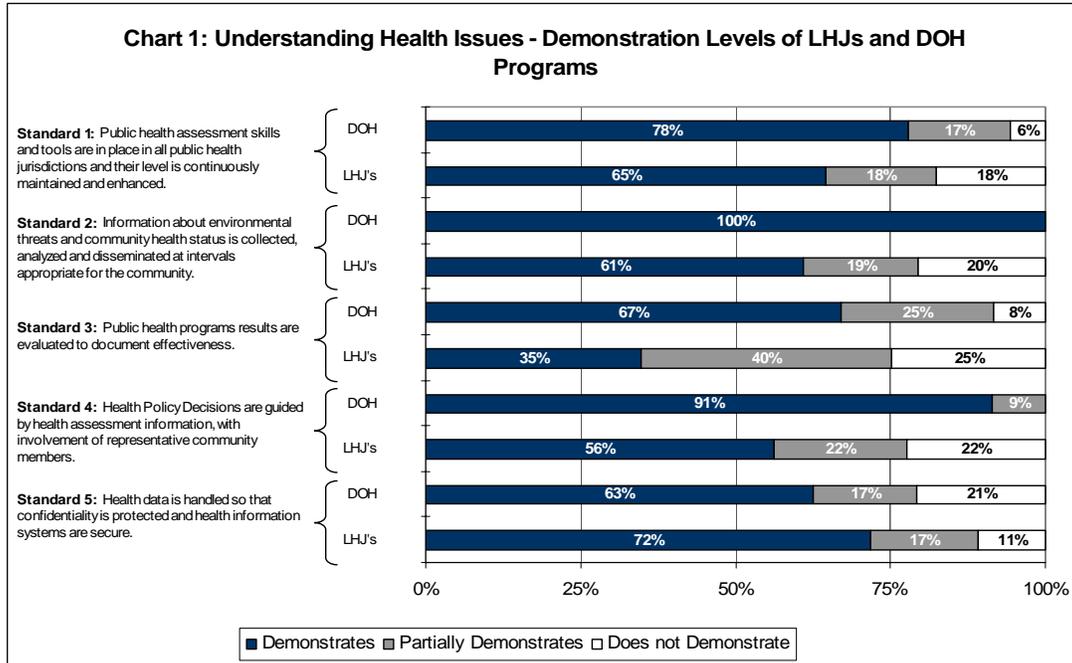
The attached report is organized to follow the Standards format. For LHJs, all measures were applicable; however, some (for example those that required certain actions related to an outbreak) were not applicable if an event had not occurred. For DOH programs, only some of the measures were applicable to each program, as identified in the DOH Matrix of applicable measures.

Program Review Results: For the measures that were assessed through program review, the scores for all programs reviewed for the individual measure were aggregated to calculate an LHJ “agency-wide” score for the measure. A separate overall system Programs Report has been developed with the aggregate results for each of the 10 programs reviewed. Please see the Programs Report for aggregate LHJ and DOH program results.

Proposed Administrative Standards Results: For the Administrative Standards, this evaluation cycle was to evaluate the standards and measures themselves and not to report site specific performance. The results of the evaluation of these standards and measures are contained in the Report of the Evaluation of the Proposed Administrative Standards.

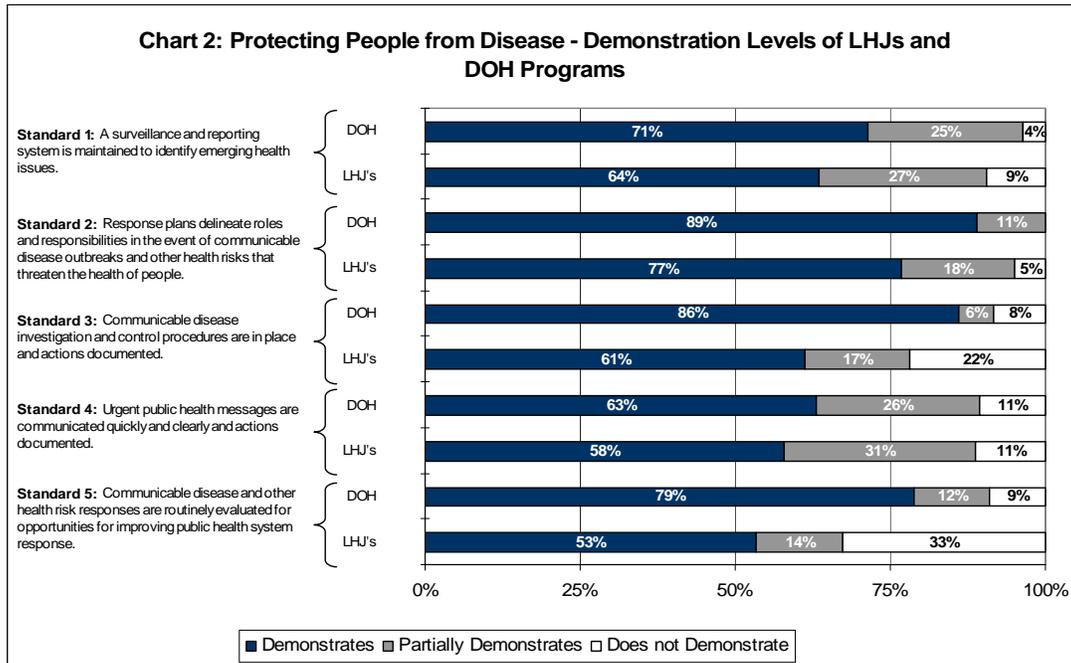
Demonstration Levels of LHJs and DOH Programs in each Topic Area

Understanding Health Issues: Standards for Public Health Assessment



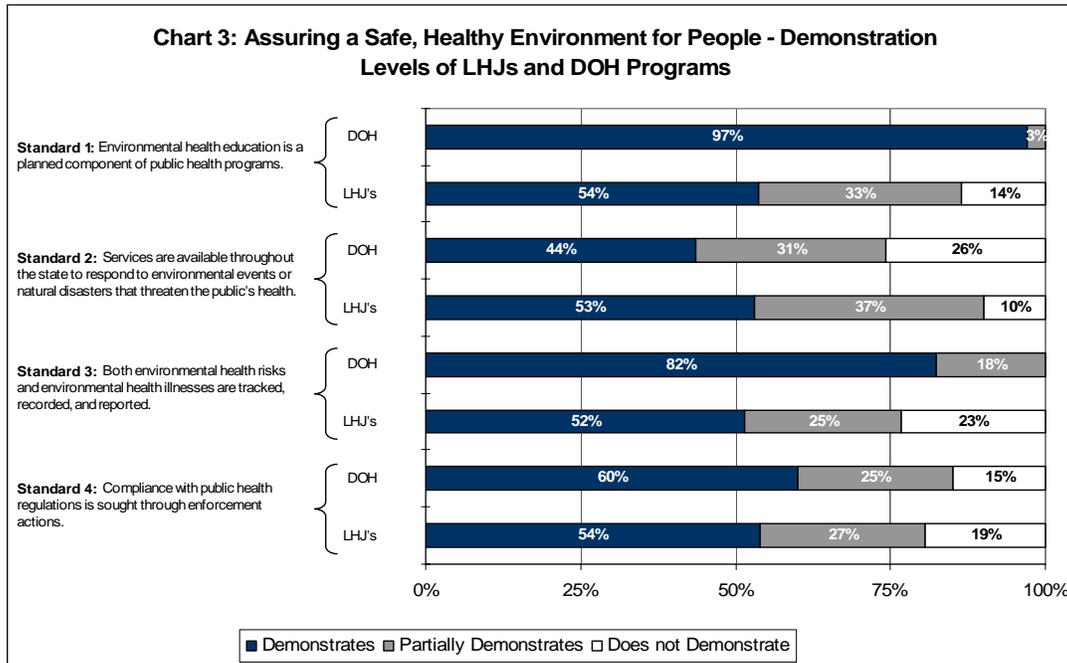
- LHJ Results:** For almost two-thirds of the measures (13 of 21 measures or 62%) in this topic area, at least 50% or more of the LHJs demonstrated performance. Four standards had more than 50% of LHJs able to demonstrate performance with only 35% of LHJs demonstrating performance in standard AS 3 [program results are evaluated]. Overall LHJ percent aggregate demonstrated performance increased from 54% in 2002 to 56% in 2005 in this topic area. This demonstrated level of performance is the second highest topic area in 2005, whereas it was the highest demonstrated topic area in 2002.
- DOH Results:** For all 19 measures in this topic area at least 50% or more of the applicable state programs demonstrate performance. Eight measures, all evaluated at just one site, had 100% demonstrated performance. All Standards have more than 60% of programs demonstrating performance across all of these measures. Overall DOH percent aggregate demonstrated performance increased from 72% in 2002 to 75% in 2005 in this topic area.

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



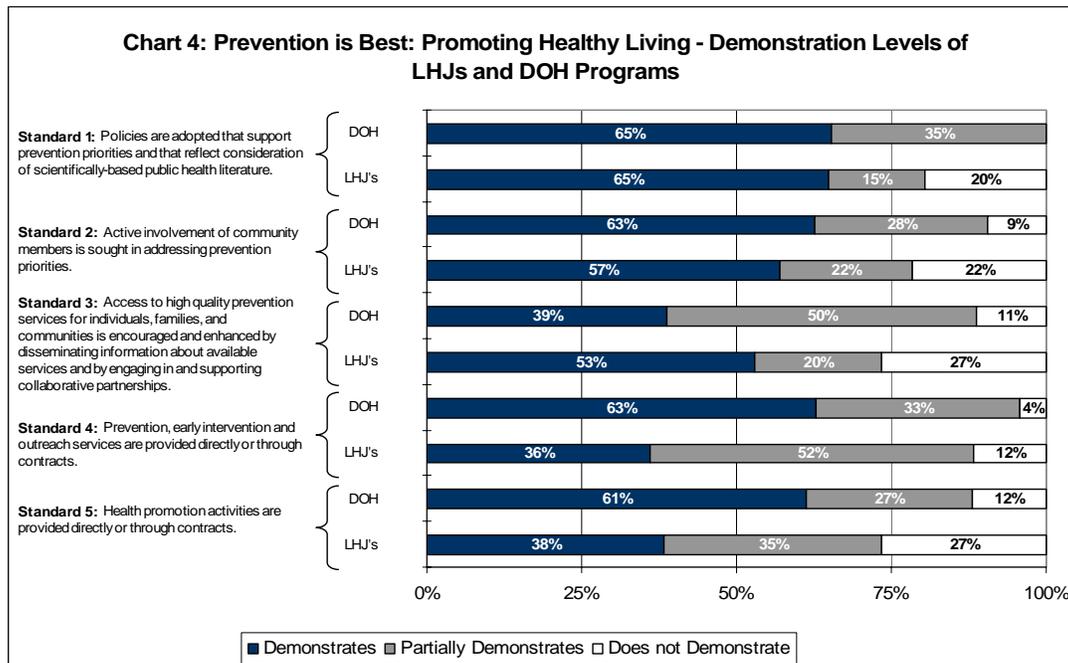
- LHJ Results:** For almost three quarters (17 of 26 measures or 73%) of the measures in this topic area, at least 50% or more of the LHJs demonstrate performance. All five standards had more than 50% of LHJs able to demonstrate performance. Overall LHJ percent aggregate demonstrated performance increased from 55% in 2002 to 62% in 2005 in this topic area. This topic area has the highest percent demonstrated in 2005 for LHJs. This demonstrated level of performance is the highest topic area in 2005, whereas it was the second highest demonstrated topic area in 2002.
- DOH Results:** For almost 90% of the measures in this topic area (23 of 26 measures or 89%), at least 50% or more of the applicable state programs demonstrated performance. All five standards had more than 60% of DOH programs able to demonstrate performance. Overall DOH percent aggregate demonstrated performance increased from 67% in 2002 to 78% in 2005 in this topic area. This topic area has had the highest percent demonstrated in both 2002 and 2005 for DOH programs.

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



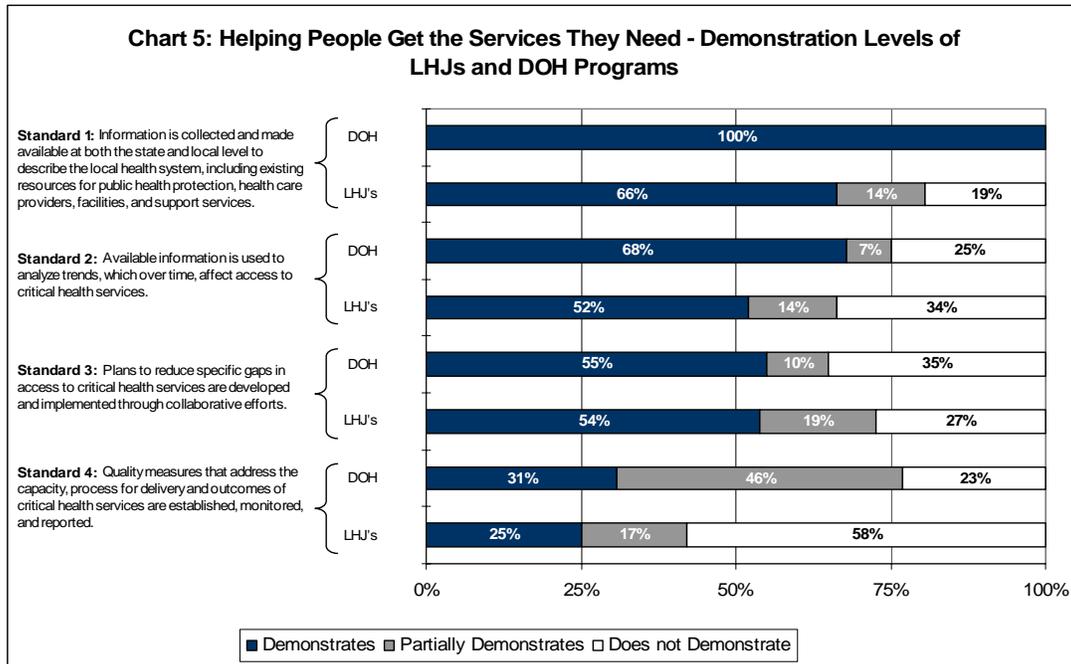
- LHJ Results:** At least 50% or more of the LHJs were found to demonstrate performance for half of the measures in this topic area (8 of 16 measures or 50%). All four standards had more than 50% of LHJs able to demonstrate performance. Overall LHJ percent aggregate demonstrated performance increased from 46% in 2002 to 53% in 2005 in this topic area.
- DOH Results:** Eight of the 20 measures in this topic area had 100% of programs demonstrating performance. In all but three of the remaining 12 measures, at least 50% or more of the applicable state programs were found to demonstrate performance. Of the three measures with less than 50% of DOH programs demonstrating performance however, two deal with training (EH2.5, and EH4.6). One of these training measures had no program able to fully demonstrate performance. While three of the standards had 50% or more DOH programs able to demonstrate performance, EH Standard 2 [*services are available to respond to environmental events*] had only had 44% of programs able to demonstrate performance. Overall DOH percent aggregate demonstrated performance increased from 40% in 2002 to 69% in 2005 in this topic area.

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



- LHJ Results:** For just over half (9 of 17 measures or 53%) of the measures in this topic area at least 50% or more of the LHJs demonstrate performance. Three of the five standards had more than 50% of LHJs able to demonstrate performance. PP standards 4 and 5 [prevention services and health promotion activities are delivered directly or through contracts] had 36% demonstrated and 38% demonstrated, respectively. Overall LHJ percent aggregate demonstrated performance decreased from 58% in 2002 to 48% in 2005 in this topic area. This topic area has the lowest level of demonstrated performance for 2005.
- DOH Results:** For more than three quarters of the measures in this topic area (17 of 21 measures or 81%), at least 50% or more of the applicable state programs demonstrate performance. Four of the five standards had more than 60% of DOH programs able to demonstrate performance. PP standard 3 [access to high quality prevention is encouraged and enhanced...] had 39% demonstrated performance. Overall DOH percent aggregate demonstrated performance decreased slightly from 60% in 2002 to 59% in 2005 in this topic area.

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



- LHJ Results:** More than half of the measures (6 of 11 measures or 55%) in this topic area were demonstrated by 50% or more of the LHJs. Three of the four standards had more than 50% of LHJs able to demonstrate performance. AC standard 4 [*quality measures for critical health services are established, monitored and reported*] had 25% demonstrated, the lowest aggregate performance level in a standard for LHJs. Overall LHJ percent aggregate demonstrated performance increased from 44% in 2002 to 52% in 2005 in this topic area.
- DOH Results:** Three quarters of the measures in this topic area (9 of 12 measures or 75%) were demonstrated by 50% or more of DOH programs. Three of the four standards had more than 50% of DOH programs able to demonstrate performance. AC standard 4 [*quality measures for critical health services are established, monitored and reported*] had 31% demonstrated, the lowest aggregate performance level in a standard for DOH programs. Overall DOH percent aggregate demonstrated performance stayed the same in 2005 as in 2002, with 51% demonstrated in this topic area.

Comparison of 2005 Performance to 2002 Baseline

Due to the major revisions in the environmental health topic area, and to the program review method of evaluation used for numerous measures, only some of

the 2005 results can be compared to the results of the 2002 Baseline. The measures that are considered comparable between the two cycles are:

- All Assessment (AS) measures, except AS 3.2 and AS 3.3 for LHJs that were evaluated through program review
- All Communicable Disease (CD) measures, except CD 3.2 for DOH and CD 3.3 for LHJs
- Prevention and Health Promotion (PP) measures in standards PP1, PP2, and PP3
- All Access (AC) measures

Significant Changes in Local Health Jurisdiction Performance

The comparison of performance between the 2002 Baseline and the 2005 Performance Assessment indicates that significant change occurred in eight LHJ measures. Of the eight, seven showed an increased percent of LHJs able to demonstrate performance, and one measure showed a smaller percent of LHJs able to demonstrate performance. Interestingly, only half of these eight measures have more than 50% of LHJs able to demonstrate performance. Even with the significant increase in percent of LHJs demonstrating performance, four measures still have less than 50% of LHJs able to demonstrate performance. See the discussion and detailed description of findings in the full report.

Table 1: LHJ Measures with Significant Changes from 2002 to 2005*

LHJ Measure	% Demonstrate		% Partially Demonstrate		% Did not Demonstrate		Strength of Change
	2002	2005	2002	2005	2002	2005	
<i>Understanding Health Issues</i>							
AS4.3L	16%	47%	13%	13%	72%	41%	.34 (+)
AS5.1L	9%	75%	84%	9%	6%	16%	.51 (+)
AS5.2L	44%	69%	25%	25%	31%	6%	.30 (+)
<i>Protecting People from Disease</i>							
CD3.4L	6%	21%	9%	21%	84%	58%	.30 (+)
CD3.5L	13%	42%	6%	3%	81%	55%	.31 (+)
CD4.2L	78%	56%	19%	35%	3%	9%	.24 (-)
CD5.6L	17%	55%	22%	9%	61%	36%	.33 (+)
<i>Helping People Get the Services They Need</i>							
AC4.2L	6%	22%	6%	9%	88%	69%	.24 (+)

Only measures that were significant at .05 and had correlations (strength of relationship) above .20 are displayed.

Significant Changes in DOH Program Performance

The comparison of performance from the 2002 Baseline and the 2005 Assessment indicates that significant change occurred in five DOH measures. Of the five, four showed an increased percent of DOH programs demonstrated performance, and one measure showed a decreased percent of programs able to demonstrate performance. Two of these five measures have less than 50% of programs able to demonstrate performance even with the increase. See the discussion and detailed description of findings in the full report.

Table 2: DOH Measures with Significant Changes from 2002 to 2005*

DOH Measure	% Demonstrate		% Partially Demonstrate		% Did not Demonstrate		Strength of Change
	2002	2005	2002	2005	2002	2005	
<i>Protecting People from Disease</i>							
CD4.4 S	0%	44%	0%	33%	100%	22%	.62 (+)
<i>Prevention is Best: Promoting Healthy Living</i>							
PP1.4 S	33%	77%	0%	21%	67%	0%	.49 (+)
PP2.4 S	0%	53%	60%	40%	40%	7%	.53 (+)
PP5.4 S	83%	23%	0%	54%	17%	23%	.44 (-)
<i>Helping People Get the Services They Need</i>							
AC2.4 S	0%	100%	67%	0%	33%	0%	.95 (+)

* Only measures that were significant at .05 and had correlations (strength of relationship) above .20 are displayed. Caution should also be taken with these results due to the small sample sizes (<30).

Recommendations: Improving Performance of the Public Health System

The recommendations fall into three areas: recommended actions for improvement in system performance, clarification and refinement of the standards and measures themselves, and the ongoing process for integrating the standards into the system and sustaining the assessment cycles.

The LHJs and DOH programs have all received individual site reports with their specific 2005 Performance Assessment 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.

Some of the recommendations reflect a value for intended variation and a need for reduction in unintended variation in the practice and delivery of public health

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

Establish and Monitor Program Goals, Objectives and Performance Measures

Recommendation: Identify specific goals, objectives, and performance measures for LHJ and DOH programs and establish mechanisms for regular monitoring, reporting, and use of results.

Evaluate Program Effectiveness

Recommendation: DOH and LHJs should conduct regular monitoring of quantifiable, specific performance measures, including the results of self-audits; compare the results to targets or thresholds, identify program areas needing improvement, and take action to improve program performance against the performance measures.

Standardize DOH Program Requirements and Templates

Recommendation:

- DOH collect and evaluate the formats that are being used now by DOH and other state programs to identify those that are consistent with the Standards (e.g., goals objectives, and performance measures, science and assessment basis for the program goals and objectives, measurement/indicators, a specific step of reviewing performance measure data and drawing conclusions for change or improvement of the program in the next period).
- Develop model templates (content requirements and format) for project applications, worksheets, program proposals, measurement, program evaluation and reporting that are consistent with and address the Standards and specific measures.
- To the extent possible (e.g., within the constraints of federal or other funding requirements), adopt the model templates in all DOH programs that contract with LHJs for services.
- Integrate this process into regional planning structures (e.g., HIV/AIDS).

Standard State Databases and Documentation Methods

Recommendation:

- Implement standardized DOH methods for data collection, analysis and reporting of program performance measures, including environmental health.
- Develop and distribute a data dictionary for all indicators in the surveillance system
- Assess whether program databases can be reconfigured to support evaluation of performance measures, described in recommendation A above.

Standard Statewide Health Indicators to Track

Health indicators can be used to measure results for a population. These can include health status or community indicators and population level outcome measures. (See Attachment J for examples of health indicators.)

Recommendation:

- Develop a set of statewide local-level health indicators from a variety of sources; best practices in WA and other states as well as data in the current system (e.g., CD, EH, STDs, BRFSS). Assure that health indicators have a data dictionary with standard definitions including the source of the data.
- Pilot in LHJs of differing sizes and complexity. Get feedback and fine tune.
- Develop the capacity for DOH to provide a report to each LHJ that benchmarks their data to their peer group and statewide.
- Monitor state wide performance on these health indicators and report to local, state and community groups.

Establish a Quality Improvement Plan

Recommendation: Use the outcome of health indicators monitoring and of program evaluations to develop and implement a quality improvement plan for the overall LHJ or the DOH Office or Division.

DOH Technical Assistance (TA) and Consultation

Recommendation: All DOH programs include information on their website and other materials for LHJs and other agencies on the scope of TA available such as establishing appropriate program performance measures, use of standard templates etc. and the process to obtain consultation from the DOH program.

Model Templates, Policies and Procedures

Recommendation: Identify the policies and procedures that should be jointly developed by DOH and LHJs. Specific policies and procedures identified for joint development include:

- Environmental health protocols for investigation and reporting
- CD protocols for investigation and reporting
- Evaluation/self-audit processes for CD and EH investigation, EH compliance activities, and outbreak management and debriefing

Training

Recommendations:

1. Establish systematic education and training processes in all local and state programs, including tracking methods to assure that LHJ and DOH staff maintain and improve their skills and knowledge in delivering public health services, including:
 - Emergency Response plan and individual staff roles in responding to emergencies
 - Methods to evaluate performance against goals and assess program effectiveness
 - Confidentiality and HIPAA requirements
 - Risk communications
 - EH investigation and compliance procedures
 - Community involvement (mobilization)
 - Health promotion methods
 - Quality Improvement methods and tools
2. Consider using multi-program training sessions for LHJ staff for contracted services, reducing the number of days away from their work to be trained by the multiple programs contracted by DOH
3. Develop non-classroom methods for delivering training sessions, including web based, videotape or DVD, and satellite downlink technologies.

Recommendations for the Standards and Measures

Changes to Standards

It is recommended that two standards be eliminated from the current set of standards and two standards in the Prevention and Promotion topic area be combined into a single standard.

Move Assessment Standard 5 [*Health data is handled so that confidentiality is protected and health information systems are secure.*] and the two measures in the standard to Administrative Standard on Information Systems.

Eliminate Access Standard 4 [*Quality measures that address the capacity, process for delivery and outcomes of critical health services are established, monitored and reported*]

and integrate the measures requiring quality improvement (QI) training and the establishment of a QI plan to new measures in the Administrative Standard, as described below.

Combine Prevention and Promotion Standards 4 and 5 into a single standard and set of measures. The recommended new standard states Prevention, early intervention, outreach, and health promotion services are provided directly or through contracts.

Changes to Measures

The following changes are recommended for multiple measures. Please see the detailed recommendations for individual measures contained in Attachment H.

Recommend a new Human Resources measure for training: Staff are trained in the following topics as evidenced by documentation of course content and specific staff attendance:

- Methods to evaluate performance against goals and assess program effectiveness
- Confidentiality and HIPAA requirements
- Risk communications
- EH investigation and compliance procedures
- Community involvement (mobilization)
- Health promotion methods
- Quality Improvement methods and tools

Recommend a new measure be added to the Administrative Standard for Information Systems to assess the contents of LHJ and DOH websites.

Recommend a new Leadership and Governance measure regarding quality improvement plans: There is a written quality improvement plan including specific objectives and performance measures reflecting community assessments and performance results; such as the health indicators, program evaluations, and outbreak response or after-action evaluations. The plan states timeframes for completion and staff responsible for specific objectives. Performance measures are tracked and reported and used to improve agency performance.

Recommendations: An Ongoing Cycle of Performance Assessment and Improvement

A continuous cycle of performance management, measurement and improvement for the Washington public health system must be established to successfully integrate these activities into all parts of the system and into the daily work. These recommendations are specific to activities for building and sustaining the performance management and accountability processes for public health.

DOH and LHJ Leadership Responsibility for Taking Action

Recommendation: Develop and implement system wide and agency specific work plans to address opportunities for improvement.

- Implement a DOH work plan for oversight of the use of the 2005 performance assessment results and improvement work being done in the Divisions, Offices and programs across DOH, with regular timeframes for reporting on progress on work plan and improvement work.
- Implement a work plan for use of the 2005 performance assessment results and improvement activities in each of the jurisdictions. Designate one person in each LHJ to ensure the implementation of improvement work plan activities.
- Jointly identify a handful of improvement initiatives that will be a shared focus for DOH and all LHJs.

Communication and Key Messages

Recommendation: Develop and implement a communications plan for the 2005 Performance Assessment Results and for the ongoing Standards for Public Health work. Develop and communicate key messages for the integration of performance standards into the daily work of Washington's public health system, including addressing long-term commitment, leadership and institutional support, and the ongoing nature of the work.

Revision of Current Performance Standards and Related Materials

Recommendation: Immediately initiate a process to revise the current performance standards, using the recommendations in this report, and in the separate Administrative Standards Report. Target completion of the revision for year-end 2006, with distribution of the new Standards for Public Health, including the new Administrative topic area, by December 2006.

- In addition, as soon as the revised Standards and measures are completed, develop revised materials, including the Self-Assessment Guide, program menus, and the DOH and LHJ Matrices to be distributed with the new Standards.
- Develop and provide a crosswalk between the new Standards and the current 2005 version to facilitate electronic site visit documentation and comparisons of performance.

Health Indicators Included in Performance Scoring

Recommendation: Identify health indicators to be included in the performance scoring for each site in the next performance assessment cycle. (See Health

Indicators recommendation above) All sites would be scored on their specific results on the same set of health indicators.

Glossary of Terms

Recommendation: It is recommended that a Glossary be developed for many of the concepts and terms used in the Standards for Public Health, and that these definitions are included in all training sessions for the Standards.

Use of Internal Reviewers

Recommendation: Establish a formal system, with appropriate funding, for selecting internal reviewers, including establishing a job description, expectations of participation, and an evaluation/feedback process. Use a team of internal reviewers to provide training and consultation to local sites and DOH programs in improving their performance and in preparing for the next cycle of measurement.

Employee Orientation, Training and Mentor Program -- Sustaining the Standards Process and Integrating the Standards into the Daily Work of the System

Recommendation: Assure that orientation to the standards and to the basic principles of performance measurement are included in the DOH general orientation curriculum and in the specific DOH program and LHJ orientation processes.

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

Recommendation: Assure that training in the content and interpretation of Standards for Public Health is provided on a regular schedule and that Preparing for the Site Visit training is provided in the three to four months before the next cycle of site reviews.

- Develop non-classroom methods for delivering training sessions, including web based, videotape or DVD, and satellite downlink technologies.
- Train a team of internal reviewers to deliver/support Basic Standards training (think of this as Standards 101).
- Provide materials, tools, and coaching to conduct Preparing for Site Visit training (think of this as Standards 102)
- Develop and conduct further training for selected DOH and LHJ staff in focused areas that apply directly to their work and responsibilities (a Standards 200 series).
- Develop and conduct training sessions based on each of the Standards Topic Areas

- Develop and conduct training sessions on Applying the Plan-Do-Check-Act Cycle in Your Daily Work

Recommendation: Develop and implement a mentor program that matches a high performing local site with an interested local site that is working toward improvement in a specific topic area or process.

The Next Cycle: Training and Site Review Timeframe

Recommendation: The next cycle of site visits should be scheduled for the spring and early summer of 2008, with site visit preparation training scheduled regularly in the fall of 2007 and winter of 2008 to assure that three to four months between training and site visit for all sites.

Site Visit Process

Recommendation: Use teams of one LHJ and one DOH reviewer, with training, coaching and initial joint visits with external consultants to conduct the assessments in the next cycle. Assure adequate funding to support the training, time and materials needed by the internal review teams. Assure that training to prepare for the site visits occurs at least three to five months prior to the site visits. Expand the site visit schedule to allow for more reviewer days at each site, and fewer site visits per week.

Performance Measurement and Reporting Database

Recommendation: The PHIP Standards Committee requests that a database be created to collect and report Standards performance data over time, including the development of regular reports of performance on the standards and on the set of statewide health indicators.