

Public Health Improvement Plan

A Blueprint for Action

December 1996

Public Health Improvement Plan Steering Committee

Bobbie Berkowitz, Chair

University of Washington School of
Public Health and Community Medicine

John Beare

Washington State Public Health Association

Dennis Braddock

Community Health Plan of Washington

Margaret Casey

Consumer

Elaine Conley

Public Health Nursing Directors

Tim Douglas (through January 1996)

Association of Washington Cities

Bill Dowling

University of Washington School of
Public Health and Community Medicine

Representative Phil Dyer

Washington State House of Representatives

Jeanne Edwards (since January 1996)

Association of Washington Cities

Mimi Fields

Washington State Department of Health

Cathy Green

Business

Tom Hilyard

Health Care Policy Board

Nancy Leer

Washington State Nurses Association

Pat Libbey

Performance Measures Technical
Advisory Committee

Ellie Menzies

Washington State Labor Council
District 1199 NW/SEIU

Ken Merry

Environmental Health

Tom Milne

Washington State Association of
Local Public Health Officials

Bruce Miyahara

Washington State Department of Health

Anita Monoian

Washington State Association
of Community Clinics

Warren Featherstone Reid

Washington State Board of Health

Rick Rubin

Foundation for Health Care Quality

Ron Schurra

Washington State Hospital Association

Mary Selecky

Finance and Governance Technical
Advisory Committee

Mike Shelton

Washington State Association of Counties

John Thayer

Environmental Health Directors

Mel Tonasket

Area Indian Health Services

Terry Torgenrud

Washington State Medical Association

Senator Lorraine Wojahn

Washington State Senate

Public Health Improvement Plan

A Blueprint for Action

December 1996



1112 SE Quince Street
P.O. Box 47890
Olympia, WA 98504-7890

(360) 753-5871
Fax 586-7424

Public Health Improvement Plan Staff and Consultants

Department of Health, Office of Health Policy

Doreen Garcia, PHIP Coordinator

Steve Kelso

Lucia Miltenberger

John Nelson (consultant)

Terry Reid

Marquita Schlender

Department of Health, Office of Health Promotion

Heidi Keller

Don Martin

Mary Deraitus

Department of Health, Office of Legislative and Constituent Relations

Kris Van Gorkom

Department of Health, Office of Planning

Joan Brewster

Washington State Senate

Don Sloma

Washington State House of Representatives

Bill Hagens

Health Policy Analysis Program,

University of Washington School of Public Health and Community Medicine

Jack Thompson

Aaron Katz

American Indian Health Commission

Joe Finkbonner

Washington Association of Local Public Health Officials

Vicki Kirkpatrick



STATE OF WASHINGTON

DEPARTMENT OF HEALTH

1112 S.E. Quince St., MS/7890, P.O. Box 47890
Olympia, Washington 98504-7890
(206) 753-5871 • (SCAN) 234-5871
TDD (206) 664-0064 • FAX (206) 586-7424

December 1996

The Washington State Department of Health and the Public Health Improvement Plan Steering Committee are pleased to present the 1996 Public Health Improvement Plan (PHIP), the second biennial report describing the framework to protect and promote health in Washington. The PHIP is a multi-year blueprint for improving the capacity of the public health system to build healthy communities.

The mission of public health is to prevent disease, injury, disability, and premature death. This includes protecting people's health from threats in the environment and promoting health through risk reduction and public education. Since 1993, Washington's public health system has been leading the nation in efforts to clearly define its role in prevention, and to define the capacity needed to do its job of improving health outcomes into the next century.

The 1996 PHIP further defines the infrastructure needed to assure healthy communities, documents improvements to date, and recommends future enhancements and improvements. The process of modernizing and improving Washington's public health system is well underway, but not yet finished.

Thank you for your interest in this plan. It is an exciting and challenging time for all of us who are working to improve the public's health in Washington.

Sincerely,

BRUCE A. MIYAHARA
Secretary

BOBBIE BERKOWITZ, PHD, RN, FAAN
Chair, PHIP Steering Committee
School of Public Health & Community Medicine
University of Washington

MIMI L. FIELDS, MD, MPH, FACPM
Deputy Secretary/State Health Officer

Contents

- 1 **Executive Summary**

- 7 **Preface**

- 9 **Chapter 1**
How healthy are we, and what is public health's part?
 - 9 Looking good, but...
 - 9 Determinants of health
 - 11 The contributions of the public health system
 - 14 The contributions of the *Public Health Improvement Plan*

- 17 **Chapter 2**
Action: Toward improved public health
 - 18 **Improving information-based decision-making**
 - 19 Community health assessment
 - 21 Report: *The Health of Washington State*
 - 22 Information Network for Public Health Officials (INPHO)
 - 22 Geographic Information System (GIS)
 - 23 Information Resource Management (IRM)
 - 23 American Indian Data Plan
 - 24 **Improving collaboration among many partners**
 - 24 Public health partnerships
 - 25 Providing clinical personal health services
 - 27 Education and training
 - 28 American Indian Health Commission for Washington State
 - 29 American Indian Health Care Delivery Plan
 - 29 Community Public Health and Safety Networks
 - 30 **Improving accountability**
 - 30 Governance of public health in Washington
 - 31 Financing of public health in Washington
 - 34 Measuring capacity and core function performance of local health jurisdictions and tribes
 - 38 Performance-based contracting
 - 39 Quality improvement
 - 40 Regulatory reform

- 43 **Chapter 3**
Recommendations
 - 43 **Information-based decision-making**
 - 43 1. Develop health indicators and objectives.
 - 44 2. Coordinate the *State Public Health Report* and *The Health of Washington State*.

Chapter 3

Recommendations (cont.)

45 Collaboration

- 45 3. Fund public health partnerships for the 1997-99 biennium.
- 45 4. Analyze American Indian Health Commission proposed definition of tribal health jurisdiction.
- 46 5. Convene a statewide dialogue to share information about collaborations among local public health, managed care plans and providers, and communities.

47 Accountability

- 47 6. Use financing principles to guide public health system financing policy.
- 47 7. Maintain a local funding base as state funding increases.
- 48 8. Provide additional state funding for public health system development.
- 48 9. Explore flexibility in federal funding.
- 48 10. Develop new or revised regulations for local health jurisdictions.
- 49 11. Examine local health jurisdiction role in clinical personal health services.
- 49 12. Evaluate local decisions related to clinical services delivery.
- 50 13. Clarify the state's role in assuring access to clinical services.
- 50 14. Clarify state and local roles in assuring the quality of health services.
- 50 15. Use the 1996 performance measure survey results.
- 51 16. Continue to develop performance measures for the core functions.

53 Chapter 4

Future challenges

57 Appendices

- 57 A. The public health system
- 61 B. Health system changes
- 65 C. Health in Washington state
- 69 D. Local Capacity Development Fund projects
- 77 E. Financing principles and fee principles
- 81 F. Measuring core functions and capacity
- 91 G. Core function capacity standards
- 101 H. Tribal health and the Centennial Accord
- 105 I. Biographies of PHIP steering committee members and staff
- 112 J. Technical advisory committee members and other contributors
- 114 K. Other available PHIP-related reports
- 115 L. PHIP statutes
- 123 M. Clinical services decision-making critical questions checklist

Executive Summary

The job of public health: Building healthy communities

What is the measure of a healthy community?

Would your community be healthy if:

- The water you drink is contaminated?
- Children smoke?
- People drive cars without wearing seat belts?
- Restaurants serve contaminated meat and seafood?
- Infants don't get immunized against disease?
- There weren't safe, convenient places to walk and play?

A healthy community requires more than medical care. It requires protection from dangers that can threaten the health of the entire population. It requires good information about the nature, magnitude, and causes of health problems. It requires education about what individuals and the community can do to reduce health risks. A healthy community assures an environment in which its members can safely work and play.

The mission of public health is to prevent disease, injury, disability, and premature death. This includes protecting people's health from threats in the environment and promoting health through risk reduction and public education.

Since 1993, Washington's public health system has been leading the nation in efforts to clearly define its role in prevention, and to define the capacity needed to do its job into the next century.

The *Public Health Improvement Plan* (PHIP) sets the framework for enhancing the public health system's capacity to protect and promote health. The process of modernizing and improving Washington's public health system is well underway, but not nearly finished.

In 1993, the Washington State Legislature approved landmark legislation that recognized the significant and distinct role of public health in assuring a safe and healthy population, and provided specific guidance and funding to improve the public health system.

The Legislature committed to funding an ongoing *Public Health Improvement Plan*, and directed the Washington Department of Health (DOH) to update it every two years.

The core functions of public health

Public health is differentiated from illness care by its focus on the health of entire populations and communities. This role is carried out through the provision of preventive and protective services.

Information is essential to this population-based approach. Good health information is helping public health agencies in Washington state communicate health risks and health enhancing behaviors and policies, and make progress in defining and reducing a variety of health concerns.

Public health may sometimes be required to be the provider of care for individuals in need of clinical services, but Washington's public health improvement planning effort recognizes that the future of public health is to invest primarily in those activities which affect the health of entire communities – the core functions of public health:

Health assessment: *Collect, analyze and report information on health status, health risks, and health resources.*

Policy Development: *Prioritize community health needs, set goals, formulate action to achieve goals, evaluate results.*

Assurance *includes the following:*

Administration: *Adopt operational procedures, direct financial and personnel systems, coordinate communication and information systems, and assure accountability for use of resources.*

Prevention: *Protect people from threats such as epidemics and environmental contaminants and promote healthy living conditions and lifestyles.*

Access and quality: *Monitor the quality of health care services, improve access, provide education, enforce standards and regulations, credential health providers, and license facilities.*

Recent key events for public health in Washington

- 1988** Institute of Medicine defines Core Functions of Public Health and population-based services.
- 1989** Department of Health established by the Legislature.
- 1990** DOH, local public health and major partners begin to define core functions approach in Washington.
- 1993** Report issued by Washington State Core Government Public Health Functions Task Force. Health Services Act passed by Legislature mandates DOH to produce a Public Health Improvement Plan every two years that will define standards for health protection and include an accounting of deficits in ability to perform core functions. Funds are provided to begin building local capacity.
- 1994** DOH and PHIP Steering Committee produce the first plan.
- 1995** Legislature implements recommendations of 1994 PHIP and funds Public Health Improvement Act to build state and local capacity and establish methodology to measure and improve health outcomes.
- 1996** Local health assessments begin and DOH produces first statewide assessment, *The Health of Washington State*. PHIP update produced by DOH and PHIP Steering Committee. Baseline information gathered about local health jurisdiction core function capacity.

The 1994 *Public Health Improvement Plan* laid the groundwork for an enhanced state and local public health system. In 1995, the Legislature declared its intent to implement the plan with the passage of the Public Health Improvement Act. The Legislature provided immediate funding for early improvements, and committed the necessary, long term support needed to achieve standards.

The 1996 *Public Health Improvement Plan* further defines the infrastructure needed to assure healthy communities, documents improvements to date, and recommends future enhancements and improvements. It represents a multi-year, multi-jurisdictional blueprint for improving the capacity of the public health system to build healthy communities.

Action: One step at a time

The 1996 *Public Health Improvement Plan* builds on the work of the past two years and sets the strategic direction of the public health system. The PHIP has brought new resources into the system and improved communication and collaboration among local and state officials and other community partners.

Three principles provide a framework for discussing both the actions taken as a result of the 1994 PHIP and the recommendations of the 1996 plan:

Information-based decision-making: Using accurate, relevant and timely information to guide public health policies and interventions, and to evaluate their effectiveness.

Collaboration: Sharing strengths and assets of the whole community—including government, business, organizations and individuals—to improve health status.

Accountability: Setting standards and following clear principles and guidelines to assure consistency in decisions at all levels and the wise use of limited resources.

Improving information-based decision-making:

Health assessment: Each local health jurisdiction is completing an initial community health assessment by June 1997 as part of its annual contract with the state Department of Health. Over a third have finished early and have begun to use the information in setting local priorities. *The Health of Washington State*, an objective appraisal of overall state

health status, health risks and health systems, was completed by the Department of Health in September 1996.

Local capacity building: Local health jurisdictions are using new state funds this biennium to complete their initial community health assessments and build capacity for ongoing health assessment. There are many projects to establish new data and surveillance systems, buy necessary technology, obtain consultation, and learn new skills. In addition, the new funds are being spent on the prevention of health problems, including multiple initiatives in environmental health, family and individual health, prevention and control of infectious and non-infectious disease and violence and injury. The information from these initial investments will help communities see changes in health status, track emerging problems, gather evidence on the effectiveness of interventions and clarify policy choices.

Information processing: New data improvement technology is in place or being developed. The Information Network for Public Health Officials (INPHO), when completed in late 1997, will link every local health agency, the state Department of Health, the Centers for Disease Control and Prevention, and the Internet. Geographic Information System (GIS) will provide a quick display of a wide range of data to public health investigators.

Improving collaboration among many partners:

Local public health projects: About \$1.1 million in new Local Capacity Development Funds have resulted in 20 partnership projects involving 25 local health jurisdictions, eight Indian tribes and such local partners as community public health and safety networks, social service agencies, schools, private businesses, and the health care system. Most have established regional public activities such as sharing of epidemiologic data and expertise.

Clinical services: Local health jurisdictions are working in collaboration with health care providers to assure access to clinical personal health services.

Tribal relations: In addition to maintaining direct relationships with each of the tribes in Washington as established by the Centennial Accord of 1989, the Department of Health is collaborating with the American Indian Health Commission for Washington State to improve the health of Indian people.

Public Health Improvement Act

The 1995 Legislature declared its intent to implement the 1994 PHIP recommendations by enacting the Public Health Improvement Act (ESSB 5253). In this statute the Legislature initiated a program to provide the capacity necessary for the public health system to improve health outcomes and to establish a methodology to measure health outcomes and the delivery of public health activities.

The statute directs DOH to:

- *Identify key health outcomes for the population*
- *Identify the capacity needed for the public health system to improve those health outcomes*
- *Distribute state funds, in conjunction with local revenues, to improve system capacity*
- *Enter into performance-based contracts with local health jurisdictions to attain the necessary capacity*
- *Develop criteria to assess the degree to which capacity is achieved*
- *Adopt rules necessary to carry out the PHIP*

“One size does not fit all.”

While local health jurisdictions may face common threats to public health, their circumstances are unique and they find it increasingly important to take actions that are a “right-fit” for their communities.

Given the range of differences, the need for community-specific approaches is clear:

- *A small rural health department may encounter a case of TB only once during a year. A large district may need to manage diagnosis and treatment for several hundred people.*
- *Driving distance to the nearest health facility is a major factor in rural communities. If the number and type of health providers is limited, public health may need to be a clinical provider.*
- *Communities within health jurisdictions are very different, too. A nutrition program that works for one group may not be embraced by another group with a different ethnic makeup and different food preferences.*

The relative difficulty or ease of arranging community participation may vary considerably from one locale to another.

Improving accountability:

Financing and fee principles: The PHIP Steering Committee developed a set of public health financing principles to guide state and local policy. Based on a Department of Health survey, which pointed out the need for uniform methods for calculating service costs, a set of principles was developed for creating and revising fee schedules at local jurisdictions.

Capacity and core function performance measurement: The Department of Health and local health jurisdictions began efforts to measure the performance of local health jurisdictions with the goal of determining the skills and resources needed to work with communities to improve health.

Quality improvement and regulatory reform: The Department of Health instituted a voluntary quality improvement program that provides written materials and technical assistance to health carriers, medical groups, and community health organizations as they develop their own quality improvement programs. In keeping with the general move toward regulatory reform, the department is analyzing the impact of rules with the goal of shifting formal enforcement action to a stronger focus on technical assistance.

Recommendations

The PHIP recommends several actions to continue strengthening the public health system to improve health:

To improve information-based decision making:

1. Develop a core set of health indicators, a broader set of selected indicators, and quantitative state health objectives.
2. Coordinate the Board of Health’s *State Public Health Report* and the Department of Health’s *Health of Washington State* so the two publications complement each other.

To improve collaboration:

3. Designate a portion of 1997-99 state funds for partnerships that build and sustain local core function capacity.
4. Analyze the American Indian Health Commission’s proposed definition of “tribal health jurisdiction.”
5. Organize statewide meetings to share information and initiate joint planning about partnerships among local public health jurisdictions, their communities, and managed care plans and providers.

To improve accountability:

6. Use the "Public Health Financing Principles" to guide the development of state and local government financing policy.
7. Require that county funding of public health not decrease as state funding increases.
8. Provide additional state funding to enable continued development of state and local core function capacity and to allow local action on public health issues identified through community health assessments.
9. Explore flexibility of federal funding to maximize its use in building core function capacity in the public health system.
10. To guide the performance of local health jurisdictions, develop Washington Administrative Code regulations that include the core public health functions.
11. Examine local health jurisdictions' role in providing clinical personal health services.
12. Evaluate access to clinical personal health services and assess the degree to which health outcomes have changed through new partnerships between public health and community providers.
13. Clarify the state's role in assuring access to clinical services.
14. Clarify state and local roles in assuring the quality of health services.
15. Use the 1996 performance measure survey results to assess capacity needs, describe progress in building capacity, provide accountability and policy direction in contractual arrangements, and guide policy development.
16. Improve performance measures for the core functions.

The next step is to develop a detailed work plan in early 1997 specifying how these recommendations will be carried out over the next two years.

A regional approach to community health assessment

Five local health jurisdictions in the southwest corner of Washington have entered into a partnership for building the capacity to conduct community health assessment. Mason, Lewis, Pacific, Grays Harbor, and Wahkiakum counties received an eighteen month \$110,000 partnership grant in January 1996. With Lewis County as the fiscal lead, the group entered into a contract for technical assistance in analysis of population data and for training on data presentation to the community. The partners plan to pool resources for hiring an assessment coordinator and epidemiologist.

The availability of funding was the incentive for beginning this cross-jurisdictional collaboration. Each county is estimating a savings of \$25,000 in the next year by taking a collaborative approach to conducting community health assessment. For a very small county such as Wahkiakum, finding the resources on its own for health assessment may not have been possible. By taking a regional approach, each local health jurisdiction will have increased awareness of how their county's health resources and risks compare. Based on the relationships that have been built through the assessment activity, there will be opportunities in the future for collaborative prevention strategies that address regional health issues.

Preface

When Richard was four years old, his teeth were smaller than they should be and nearly black. They hurt all the time. Richard never smiled and didn't play with other kids in his Head Start class.

This was in 1994. Fortunately for Richard, something was happening in Thurston County that would eventually make a big difference in his life. This "something" was a collaborative local public health effort with emphasis on: *health assessment* to determine the nature and extent of health problems, *policy development* to make decisions about what problems take priority and what should be done about them, and *assurance* that effective action gets taken.

This approach was encouraged statewide through the first *Public Health Improvement Plan* and initiated locally in Richard's community by the Thurston County Health Department, one of 33 such local health jurisdictions in Washington.

The Thurston County Health Department did not take on the entire responsibility for addressing all of the county's pressing health needs. It served, rather, as the convener of a community process and as the provider of objective information on health issues.

With the backing of the Thurston County Commission (whose members are also the local Board of Health) the health department convened a Community Health Task Force that spent many months discussing a broad range of health issues, considering data, and making decisions about where to take action.

Some of the data indicated that incidence of dental disease was very high in Thurston County. It also became apparent that no dentists in the county accepted Medicaid coupons as a matter of general practice; dental care for Medicaid recipients was sporadic and hard to find. As a result of this information, the Community Health Task Force identified dental disease as one priority health issue for the county.

The Thurston County Children's Dental Health Coalition was one of several groups initiated by the task force following its assessment and prioritization of health issues. The purpose of the coalition was to address the identified problem and develop intervention strategies. The co-chairs of the coalition were the president of the county dental society and the Head Start health coordinator. Members included community dentists and dental hygienists, a pediatrician, and representatives from a local hospital, a health maintenance organization, an inter-tribal planning agency, a local school district, several civic organizations, the state Department of Health's dental program, and the Thurston County Health Department.

The results of the coalition's action include:

- A survey was conducted in Spring 1995 in schools in which 30 percent or more of the students participated in the federal free lunch program. Surveyors selected children randomly, did a visual

The Public Health Improvement Plan sets the strategic direction of the public health system relative to the greater health system in which it operates. It is about how communities in Washington State, and the state as a larger community, can best help people live healthier lives.

Family resource centers developed in island county

The Island County Health Department has been a leader in a community-wide process to improve access to health services on Whidbey and Camano Islands.

In 1990 the health department verified access problems, particularly for low and moderate income families, to primary care and social service programs. The problem was two-fold; there were an insufficient number of providers and a lack of adequate facility space. The health department acted as the convener for a community process to gather information about the scope and mix of services wanted and the proposed locations. With the health department as the lead agency, a coalition of public and private organizations applied for and received \$1.5 million in federal community development block grants. Combining funds from local government, plans were made to build family resource centers at three sites; North Whidbey, South Whidbey, and Camano Island. Each community has become involved in designing the facilities and tailoring the services to their unique needs.

With oversight from the health department, the Island County Public Works Department is constructing the facilities which will be county owned and offer a below-market rental rate.

The North Whidbey Family Resource Center has opened, with South Whidbey and Camano Island centers to open within the next year. The health department will substantially decentralize and offer a number of personal and environmental health services at the three centers.

screening, and gathered demographic data and information about insurance coverage and access to health care.

- The dental society recruited area dentists to “adopt a school” where they would provide dental health education, screening exams, and referrals for dental sealants. Some dentists and their staff have visited classrooms, and the number of participating dentists is increasing.
- Dentists are donating services for pre-sealant screening and volunteering to provide follow up services to children and their families.
- The coalition secured additional funding, including grants, to increase the capacity of the community dental clinic.
- A state Department of Health grant to purchase portable equipment has enabled community clinic hygienists to apply sealants on-site in school for second graders.
- A local pediatrician is working with all dentists and family practice physicians to encourage prescribing fluoride drops for infants and young children.
- There is a new campaign to increase awareness of baby bottle tooth decay. A key part of this is to train Head Start mothers to be peer educators.
- A survey of high school students, similar to one conducted in elementary schools, is planned for Spring 1997.

Richard was one of the children who received care. As a result of action by the Thurston County Children’s Dental Health Coalition, and with Medicaid funding, his cavities were filled and he received a thorough cleaning of his teeth. His family also received education in good dental practices. Richard now smiles, plays with others in his Head Start program, and is much more sociable than before. And his teeth no longer hurt.

The role of the local health department in all of this was not as a service provider or major source of funds. The Thurston County Health Department started the process, coordinated the work of multiple community partners, and collected and presented data and information. Now there are new community partnerships to improve access to dental care. The community is invested in solving the problem and actively working for change. And many children are getting the direct benefits of this change.

Richard is one of many children in the community who are now receiving dental care as a result of action by the Thurston County Children’s Dental Health Coalition—care they once had no hope of getting. The coalition is an example of many similar groups that have been galvanized into action in Thurston County and other Washington communities through this “core function” approach to public health. In communities all over the state, local health jurisdictions have been working with others to find local solutions to local problems.

Chapter 1

How healthy are we, and what is public health's part?

As the story of Richard's teeth illustrates, there can be many reasons for both good and poor health. This is true both for individuals and for groups of people, including large populations. This chapter summarizes what we know about health in Washington state, the major determinants of health, and the influence of the public health system on those determinants.

Looking good, but....

The health of Washington's population is improving. Across a broad spectrum of major health indicators, statewide trends since 1980 are positive more often than not. Examples include declines in heart disease deaths, motor vehicle deaths, and infant mortality, improvements in access to prenatal care, and lower incidence of many infectious diseases. When compared with the United States as a whole, for the great majority of key health indicators, Washington currently looks as good as or better than the nation.¹

Despite this generally positive overall picture, significant health challenges remain. There are continuing differences between the general health status of the total population and that of some groups that have significantly worse health outcomes for many indicators. There are local areas where a particular health problem may be very serious despite the fact that the statewide picture looks positive. There are also a few health problems that have been getting worse in Washington in recent years, for which we are currently worse than the nation, or both.

While Washington's population is not the healthiest in the nation, it is definitely healthier than average and getting more healthy over time in many respects. (See Appendix C for a more detailed summary.)

Determinants of health

There are several major determinants of the general health of a population. Each can be influenced by the public health system.

The major known determinants of our health are:

Socioeconomic conditions. Poverty, unemployment, lack of education, and other indicators of low socioeconomic status are often associated with higher rates of health problems. Compared to the U.S. as a whole, the people of Washington are relatively prosperous and well-educated. Through data collection and analysis, the public health system helps

The real causes of health problems

Most preventable health problems in our society—including about half of all deaths—are caused by tobacco use, improper diet, lack of physical activity, alcohol misuse, microbial and toxic agents, firearm misuse, unsafe sexual behavior, motor vehicle crashes, and illicit use of drugs.

The environment and community in which we live affect our ability to make good choices about our health. The extent to which we adequately educate our children, provide opportunities for jobs, and ensure a clean and safe environment will make a difference.

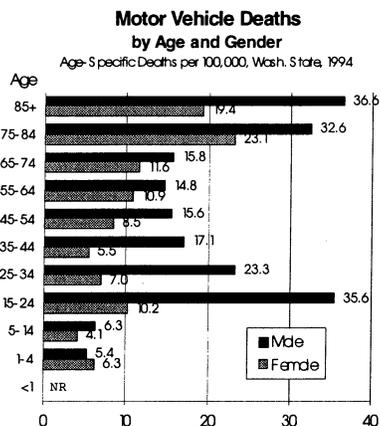
While access to health care is critical, it will not, in and of itself, fully address these fundamental causes of illness, injury, disability, and premature death.

The element of personal and community responsibility in these causes of health problems is inescapable. With the possible exception of some microbes and toxic agents, all of the causes listed above are primarily a result of human behavior.

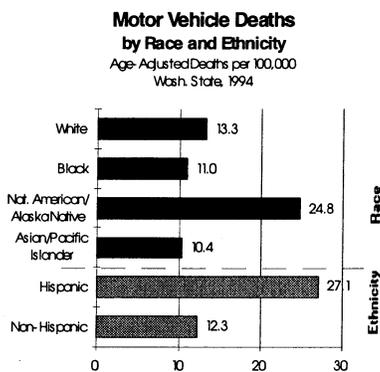
¹ See *The Health of Washington State*, published by the Washington Department of Health, September 1996.

Variable health problems

In a population, the extent of any given health problem such as motor vehicle deaths will vary. Some variation is by demographic groupings (age and gender, for example):



Or the variation may be by race or ethnicity:



There is also geographic variation. For the years 1992-1994, the average motor vehicle death rate in Washington was 13.7 per 100,000. County by county, this rate varied from a low of 7.5 to a high of 51.4.

identify and make known health problems that may be related to poor socioeconomic conditions. In addition, community public health nursing has traditionally been an important source of assistance to low income families.

The physical environment. In the areas of outdoor air quality, safe drinking water, cleanup of hazardous waste sites, and food protection, much has been done in Washington the last 20 years to decrease the threat of illness and disease transmission, but population growth will continue to put more stress on the environment, particularly in the area of water quality and availability. The public health system has a strong environmental health component with major responsibilities in the areas of water quality, food safety, radiation protection, and control of toxic substances.

Access to and quality of health care. In Washington, about 88 percent of the population have health insurance or other financial coverage, and about 12 percent lack health insurance coverage. This is better than the nation as a whole, but still represents a large number of people who have no health coverage.

In terms of total statewide supply of health care practitioners (the ratio of practitioners to population) Washington is doing well compared to the nation. There are some supply problems, however, in specific geographic areas of the state—primarily rural areas.

Public health monitors and improves the quality of health care by licensing and certifying health professionals, health services, and health care facilities. Public health influences access to health care by sometimes providing critical services—such as immunizations, family planning, and control of infectious disease—primarily to low income families and other vulnerable populations.

Behavioral risk and protective factors. Health is to a great extent determined by personal behavior. For most important measurable personal risk and protective factors (for example, smoking, alcohol and drug use, exercise, nutrition and diet) Washington residents appear to take better care of themselves than Americans as a whole.

The influence of public health on behavioral risks is twofold: One is through assessments that provide information on the nature and extent of risks. The other is through programs that promote healthy behavior or reduce unhealthy behaviors.

Genetics. Genetics can play a part in a wide variety of health problems, including birth defects, mental retardation, coronary heart disease, cancer, diabetes, and pregnancy losses. Genetic disorders, once considered to be rare events, are now recognized as widely occurring. They have far reaching effects on families and often create long term needs for health, educational, and social services.

Public health influences the genetic component of health by supporting a variety of regional laboratories, clinics, and support services to assist individuals and families.

The contributions of the public health system

Historic perspective

Public health has had an enormous impact throughout the twentieth century in reducing health threats and improving the quality of life for Washington's residents. In 1900, the most common causes of death in Washington state were influenza, pneumonia, and tuberculosis—all infectious diseases that can be reduced through application of public health practices. The state Board of Health reports from that era focused on the reporting and quarantining of people with infectious diseases such as smallpox, measles, scarlet fever, whooping cough, diphtheria, and cholera. The rate of infant mortality was over ten times higher than today, and almost one quarter of all deaths occurred among people in their 30s and 40s. Injuries were a major cause of death, particularly among children and young adults.

In 1994, the four leading causes of death in the state were noninfectious diseases: heart disease, cancer, stroke, and chronic obstructive pulmonary disease. After unintentional injuries in fifth place, influenza and pneumonia came in a distant sixth.

Public health played a major role in controlling the diseases and injuries that so often killed children and young adults in the early part of this century. Environmental and occupational health programs have continued to reduce risks, save lives, and increase life expectancy, even as the emergence of HIV/AIDS as one of the top ten killers has shown that infectious disease control needs continuing attention.

The mission and core functions of public health.

The mission of public health is to prevent disease, injury, disability, and premature death. This includes protecting people's health from threats in the environment and promoting health through risk reduction and education.

To carry out this mission, public health agencies perform basic core functions. In 1988, the national Institute of Medicine defined a population-based approach to these core functions in a comprehensive national planning document entitled *The Future of Public Health*. The 1994 *Public Health Improvement Plan* (PHIP) used the Institute of Medicine's report as a foundation for further defining the core functions as practiced by state and local health jurisdictions in Washington state:

Health assessment consists of collecting, analyzing and reporting information on health status, health risks, and health resources in a community. It includes examining health trends and outcomes, monitoring access to and quality of community health services, performing community health assessments, conducting epidemiological investigations, evaluating findings on environmental health and behavioral risk,

Public health: A wise buy

Throughout history humans have suffered under the scourge of communicable disease. The bubonic plague killed up to 2 million people a year during the 14th century. In 1918-1919 an influenza epidemic killed nearly 1 million U.S. citizens and up to 34 million world wide. More than 1 in 10 persons died in some U.S. cities during that epidemic. Other diseases such as smallpox, rubella, pertussis, cholera, mumps, measles, and polio once ravaged society.

Fortunately, these diseases no longer wreak such devastation in the U.S. Immunizations, safe drinking water, milk pasteurization, rodent control, and other public health programs have dramatically lowered the number of cases of many communicable diseases. In its first twenty years, the measles vaccine is estimated to have prevented 52 million measles cases, 17,400 cases of mental retardation, and 5,200 deaths. Smallpox has been completely eradicated from the world.

Every dollar spent on measles vaccine prevents an estimated \$16 in direct medical costs and \$5 in lost productivity. By eradicating smallpox, the U.S. saves not only the cost to treat the disease, but no longer spends some \$150 million a year in prevention programs.

Prevention: The business of public health

The first and foremost public health activity is prevention of disease, injury, disability, and premature death. Public health carries out prevention by influencing the environmental conditions and personal behaviors that create health risks.

Prevention can be classified into three types:

***Primary** prevention reduces susceptibility or exposure to health threats before a problem occurs (for example, childhood immunization or education of food handlers).*

***Secondary** prevention detects and treats a condition in its early stages (for example, sexually transmittable disease contact tracing, investigation of a measles outbreak).*

***Tertiary** prevention responds to the effects of a disease, injury, disability, or problem (for example, HIV/AIDS case-management, repair of failed septic system).*

and disseminating this information in a timely manner and usable form to the community.

Policy Development is an ongoing process of working with community partners to prioritize health needs, set goals, formulate action to achieve goals, and evaluate results. This includes establishing collaborative relationships, sharing information with policy makers, securing resources, integrating the role of the public health agency with other health providers, and measuring the impact of policy on the community.

Assurance was defined in the 1994 PHIP as including the following:

Administration includes the responsibility to adopt supportive operational procedures, direct financial and personnel management systems, coordinate communication and information systems, and assure accountability for the use of resources.

Prevention involves protecting the individuals, families, and the community from threats such as epidemics and environmental contaminants and promoting healthy living conditions and lifestyles. It includes the responsibility to organize the provider community around preventive services, reduce exposure to environmental hazards, influence individual behaviors and community norms, and coordinate the delivery of health services of public health significance in the community.

Access and quality includes the responsibility to monitor the quality of personal health and environmental services, provide education, enforce standards and regulations, credential health providers, license facilities, and achieve and maintain access to health services in the community.

Population-based prevention

The first and foremost intervention to improve health is prevention, and the most gains in health are made when all sectors of society work together. Public health is a major part of our complex health system and a leader in efforts to build healthier communities. Public health often helps to meet the health goals of individuals, families and whole communities through activities designed to reach the population of a community. These population-based activities provide health surveillance, education, early disease detection, injury prevention, and environmental health programs in a way that affects the entire population or a part of the population such as a neighborhood.

Keeping pollutants out of ground water, rivers, and recreational water (for example, through regulation of on-site sewage systems) reduces exposure of people to disease-causing toxins and infectious agents. Advising people about the correct temperature to cook hamburger helps prevent the very serious consequences of foodborne diseases such as E coli. Preventing unintended pregnancies helps thousands of teenagers and adults make wiser choices about when to begin parenthood.

These population-based public health services are the mainstay of public health, accounting for almost 90 percent of all public health expenditures in Washington, and are discussed throughout this report. The remaining expenditures are mostly for clinical personal health services provided by local health jurisdictions in a variety of ways depending on local priorities.

Public health's role in assuring access to and quality of clinical personal health services

Clinical services are a relatively small proportion of public health service provision in Washington, and they account for only a small percentage of total public health expenditures. The level and scope of clinical personal health services provided by local health jurisdictions vary greatly across the state. The services include family planning and reproductive health services, prevention and control of communicable disease, and community protection against vaccine-preventable disease. Local health jurisdictions have historically provided clinical services to:

- Protect communities from threats to health posed by individuals with highly communicable diseases such as sexually transmitted diseases, bacterial meningitis, and tuberculosis.
- Provide services to people who have not had adequate income or health insurance coverage to access the health care system.
- Provide services to people who face non-financial barriers to care (for example, transportation or language difficulties) which limit their access to the private health care system.

The 1994 PHIP recommended a "clinical personal health services transition" of certain clinical services from public health to private health coverage based on the needs of the community. This recommendation was based on the assumption that all residents of Washington state would have health insurance coverage by 1999, as mandated in the Health Services Act of 1993. In 1995 the state law was changed, eliminating the requirement for universal access.

Public health jurisdictions currently face an uncertain and changing environment in which they must assure access to and quality of clinical personal health services. This uncertainty stems from at least four factors:

- 1) The health care system is being transformed by aggressive strategies of private and public purchasers and provider efforts to merge and consolidate. The combination of these changes is confusing for enrollees and patients, who may be required to change health plans and providers.
- 2) More and more people are enrolling in managed care plans. In some communities this is resulting in a loss of revenue-paying clients at public clinics.
- 3) The 1996 enactment of federal welfare reform separates eligibility of low income families for cash assistance from Medicaid eligibility. It is

Six days in October

"It's not going to be possible to eradicate the presence of E. coli 0157 (the deadly strain of that bacteria)," said a senior state epidemiologist. "The best that can be done is to emphasize prevention and promote efforts to quickly identify and curb outbreaks." By all accounts, the latter was accomplished by state and local public health during a six day period in October 1996.

October 25: After the Seattle-King County Department of Public Health confirmed eight recent cases of E. coli 0157, they and the state Department of Health put out an alert to all local health jurisdictions, King County hospitals, and 500 medical providers.

October 29: A scientist at the University of Washington School of Public Health and Community Medicine, through a genetic analysis, determined that the outbreak had a common source.

October 30: After an extensive investigation by state and local epidemiologists, the Seattle-King County Department of Public Health announced that a common source had been identified. A brand of non-pasteurized apple juice was pulled from supermarket shelves that afternoon, one day before the biggest "apple juice holiday" of the year—Halloween.

"I imagine we saved a few lives by nipping this thing in the bud," a University of Washington microbiologist said.

New Alliances

In many communities, health care providers and health insurance plans know the local health department or district only as a provider of direct services. Many local health jurisdictions are using this as an opportunity to forge closer alliances with community providers and move their roles to a broader population-based focus.

St. Joseph's Hospital in Whatcom County is working with the Whatcom County Health Department to improve the health of the community. The local health department is acting as a catalyst to bring together the hospital, community agencies, providers, and the Whatcom Medical Bureau. St. Joseph's has begun providing funding for additional staff with specific skills and expertise to participate in the local community assessment project.

The Asotin County Health District helped form a community-based planning group, composed of social and health services workers. The purpose of the group is to build cooperative partnerships to improve the health of the community.

not entirely clear how these changes will affect access to and quality of health care.

4) The cost of health coverage appears to be increasing. This may result in a reduction in the number of people covered by health insurance.

Regardless of changes in the health system, public health has a responsibility to control and reduce exposure of the population to hazards, factors, or conditions that may cause disease, disability, injury, or premature death. To meet this responsibility, public health must maintain the capacity to assure :

- Surveillance, diagnosis, and treatment of communicable diseases.
- Maintenance of immunization levels in communities, especially among children, according to recommended public health schedules.
- Access to reproductive health services in the community.
- Access to health care services for vulnerable populations.

The challenge for local public health jurisdictions is to assure that the health of the community is improved and protected in a complex environment. It will continue to be a high priority for local health jurisdictions to form partnerships with community health care providers and to engage community leaders in planning and health systems development. See Appendix B for a more complete discussion of changes in the health system.

The contributions of the Public Health Improvement Plan

While there is evidence that people in Washington state are becoming healthier and that a good share of the credit goes to the public health system, there is continuing need for system-wide changes. Many important public health activities are relatively invisible to the people who both pay for them and benefit from them. In many respects, public health is like other emergency preparedness activities that must maintain readiness to respond to problems that may occur.

In 1990, the Washington Department of Health, local health jurisdictions, and their major public health partners began to define the ability of the state's public health system to use the core function approach. The Legislature then endorsed this effort by requiring, in the Health Services Act of 1993, that the Department of Health develop an official *Public Health Improvement Plan* (PHIP) and update it every two years. The plan must include a detailed accounting of the deficits in the core functions, define standards for health protection through assessment, policy development, and assurance, and determine whether or not communities are able to meet those standards. The plan must also recommend strategies and a schedule for improving public health programs throughout the state, and recommend a level of dedicated funding for public health services. See Appendix I for a description of

the PHIP Steering Committee that oversees development and implementation of the plan.

The results of the initial study and recommendations for improvement were published in the 1994 PHIP, which included standards for core function capacity as well as outcome standards for improved health status. The 1994 PHIP also included recommendations for financing and governing the public health system. In 1995, the Legislature passed the Public Health Improvement Act into law. Passage of the act demonstrates the Legislature's commitment to implement the PHIP recommendations and to provide the public health system with the necessary capacity to improve the health outcomes of the population. (See Appendix L for the PHIP related statutes.)

The first *Public Health Improvement Plan* proposed significant additions to public health funding in the state, phased in over six years. It recommended adding \$104 million per year to the public health system by the Year 2001, primarily for carrying out the core functions of public health and engaging in primary prevention of health problems. Over the last two biennia, the Legislature has appropriated state funds for public health improvement. First, to assist local health jurisdictions in building core function capacity, the Legislature appropriated \$10 million in the 1993-95 biennium, then added \$4.75 million in the 1995-97 biennium. These funds are called *Local Capacity Development Funds* (see Appendix D). Second, the Legislature appropriated \$10 million in 1993-95 for specific prevention activities, such as teen pregnancy prevention and immunizations, and an additional \$1 million in 1995-97 for teen suicide prevention. Third, the Legislature appropriated \$1 million in 1995-97 to build core function capacity at the state-level which funded several initiatives such as Information Resource Management, Geographic Information System, and community assessment support. Finally, to build system-wide capacity, the Legislature added \$3 million in 1995-97 for education and training of public health professionals and for implementing an integrated secure computer network linking local, state, and federal health officials.

Across the state, local health officials and concerned community members are working together to determine what are the most important public health problems facing their communities. They are deciding what solutions will work best for them. They have initiated nearly 200 programs designed to improve the health of their communities and to strengthen the public health system at the local level. The majority of funding for these community-based efforts was provided by the Legislature to help implement the *Public Health Improvement Plan*. Most of these *Local Capacity Development Funds* are distributed to jurisdictions based on population size. These funds allow communities the ability to move away from single issue categorical programs to locally developed priorities and solutions, thereby respecting variation among communities. Part of the funds are also awarded on a competitive basis as an incentive for local health jurisdictions and other community partners to achieve system improvements that cannot be attained, or sustained, by a single entity. Twenty such collaborative efforts are underway, and they

Public Health Improvement Act

The 1995 Legislature declared its intent to implement the 1994 PHIP recommendations by enacting the Public Health Improvement Act (ESSB 5253). In this statute, the Legislature initiates a program to provide the capacity necessary for the public health system to improve health outcomes and to establish a methodology to measure health outcomes and the delivery of public health activities.

The statute gives the following responsibilities to DOH:

- *Identify key health outcomes for the population*
- *Identify the capacity needed for the public health system to improve those health outcomes*
- *Distribute state funds in conjunction with local revenues to improve system capacity*
- *Enter into performance-based contracts with local health jurisdictions to attain the necessary capacity*
- *Develop criteria to assess the degree to which capacity is achieved*
- *Adopt rules necessary to carry out the PHIP*

are changing the way public health professionals practice and interact across the state.

The *Public Health Improvement Plan* sets the strategic direction of the public health system and is an ongoing, incremental effort building on the existing system. The new funds described above, reallocation of existing resources, and collaborative efforts have all played a role in core function capacity building. The next chapter describe actions taken over the last two years as a result of the 1994 *Public Health Improvement Plan* and passage of the Public Health Improvement Act. Chapter 3 includes recommendations from the PHIP Steering Committee for further action to take during the next several years—action that will play a large role in continuing improvement of the health of Washington residents. Chapter 4 discusses some of the challenges that remain.

Chapter 2

Action: Toward improved public health

Assessment, policy development, and assurance: These are the cornerstones of the core function approach that the public health system has adopted as the best way of fulfilling its responsibilities to promote and protect health. They are as applicable to specific programs designed to focus on just one health issue as they are to the statewide public health system. Just as the 1994 PHIP explained the core function approach and set the stage for system change, the current PHIP tells how this approach is being understood and incorporated into the work of every local health jurisdiction and the state Department of Health, as well as in communities by other organizations and individuals interested in improving health.

Although assessment, policy development, and assurance are discussed as separate functions, in reality they are fluid and interrelated. Shortly after publication of the 1994 PHIP, three common principles emerged as those on which any public health system or program should operate (see sidebar).

These principles reflect the dynamic nature of public health work. Putting them into practice enables public health professionals to understand health risks in detail, to identify health priorities, to choose interventions wisely, and to evaluate the effectiveness of those interventions.

Information-based decision making encompasses all the core functions, recognizing that decisions will be more effective if they are made with accurate, timely information. While it is essential to have objective quantitative information gathered through scientific processes, it is also important to have information about community values, perceptions, and traditions. For that reason, the principle of collaboration is closely linked with information based-decision making. All interested parties should have access to the same information so they can mutually decide what community health priorities should be and the most effective courses of action to address them.

The principle of **collaboration** does not imply that community partners simply identify health issues and interventions that the public health jurisdiction must then carry out. Putting this principle into practice means that those partners will commit their time and resources to carrying out interventions and evaluating their effectiveness.

Building the relationships necessary for successful partnerships requires time to develop trust and communication among people who may have no history of working together. Taking the time to build these relationships is critical, since collaboration is essential to leverage available resources, avoid unnecessary duplication of services, and implement

Operating principles

Information-based decision-making: *Accurate, relevant, and timely information is essential to guide public health policies and for evaluating the effectiveness of those policies.*

Collaboration: *Collaboration between governments, communities, organizations, and individuals is necessary to improve the health status of the population.*

Accountability: *Accountability for the results of decisions and actions in the public health system is essential to make the best use of limited resources.*

More than just saying no

A hospital-based study in Spokane found that a significant number of women from all socioeconomic levels were abusing drugs during pregnancy. In providing that information to the community-wide Health Improvement Partnership, the Spokane Regional Health District helped focus activity to reduce drug use among pregnant women. The health district, along with 15 public and private agencies, developed a system for coordinating referrals and follow-up. In the past year, that system doubled the number of substance abusing women identified and assisted during pregnancy. Significant savings are being realized as a result of this system-wide coordination. There are short term savings in medical costs in treatment of drug-affected babies, while future savings will occur in social, educational, and entitlement costs. Mothers who have received services say it has made a real difference in their lives.

successful public policy that is responsive to community needs. Collaboration is an essential component in assuring accountability.

The principle of **accountability** is linked to the core function of assurance. There are multiple levels of accountability—to the Legislature, to local boards of health, to communities—but in the final analysis, the public health system is accountable to all the people. It is they who pay for the system and who benefit from its protections.

Accountability requires answers to two questions: Is the public health system effectively doing its job to promote and protect health? Does the system have the capacity it needs to do its job? Answering these questions requires ongoing evaluation of strengths and weaknesses in individual local health jurisdictions, their relationships with community constituencies, and their ability to collect and use scientific data regarding changes in health status of their community members.

Because the public health system is funded through several different sources, it must negotiate with local, state, and federal entities when making budget decisions. For that reason, it is valuable for the public health system to have clear principles and guidelines that can be used to bring some consistency to funding decisions. This, too, will enhance the accountability of the public health system for the efficient use of resources.

Implementation of the operating principles has been assisted by an infusion of new state funds and reallocation of existing funds supporting multiple activities, many of which are described in this chapter. Some of these activities are at the state level, some are regional, and some are local.

Improving information-based decision-making

Principle: Accurate, relevant, and timely information is essential to guide public health policies and for evaluating the effectiveness of those policies.

As a critical first step in implementing the *Public Health Improvement Plan*, the public health system made a significant investment over the past two years to build its health assessment capacity. This helps answer questions: How healthy are people in Washington compared to the nation? What has happened over time? What are the significant health problems statewide and in specific communities? It also raises new questions: How should new information from state and community health assessments influence decisions about how resources are used? What health issues are communities really concerned about? How can all this new information be communicated effectively to policy makers and the public?

This section reports on progress that has been made over the past two years in improving health assessment capacity.

Community health assessment

Since 1994, the Department of Health has developed budget priorities and contract requirements designed to strengthen local public health agencies' capacity to do health assessment. While most local health jurisdictions are currently engaged in projects to publish local health information, the need for assessment will not end with a single report. Communities need information they can understand and use. They will always demand improved information for decision-making and will increasingly come to rely on health information systems. The ability to do health assessments requires specialized skills in the data collection, analysis, and presentation; it requires development and maintenance of systems that collect comparable information over time, so trends can be observed and benchmarks established.

Local jurisdictions used about 30 percent of the new state funds made available to them this biennium to build health assessment capacity. There were 54 separate projects to establish new data and surveillance systems, buy necessary technology, obtain consultation, and learn new skills. The information from these initial investments will help communities see changes in health status, gather evidence on the effectiveness of interventions, clarify policy choices, and track emerging problems.

Each local health jurisdiction, as a part of its annual contract with the Department of Health, is required to complete an initial community health assessment by June, 1997. At a minimum, each local health jurisdiction must:

- Gather and analyze data regarding the demographics, health status, health problems, risk behaviors, and health service system for their county or district.
- Include information about the capacity of local systems (such as health or social services providers).
- Assess their own capacity to perform the core functions described in the PHIP.
- Involve the community in identifying health problems and formalizing and publishing assessment results.
- Develop a strategy to use health assessment information in the formulation of health policy.

Most local health jurisdictions have spent from one to two years developing their health assessment report, have invested considerable staff time, and have actively engaged community members in the health assessment process. Each process is unique and reflects the talents and priorities of individuals who live there. More than one-third of the local health jurisdictions have finished their initial documents early and have

Health assessment: The national perspective

In 1988, The Future of Public Health, a report by the Institute of Medicine, had this to say about the importance of public health's role in health assessment:

"Every public health agency should regularly and systematically collect, assemble, and make available information on the health of the community, including statistics on health status, community health needs, and epidemiologic and other health problems. Not every agency is large enough to conduct these activities directly; intergovernmental and interagency cooperation is essential. Nevertheless, each agency bears responsibility for seeing that the assessment function is fulfilled. This basic function of public health cannot be delegated."

“One size does not fit all.”

While local health jurisdictions may face common threats to public health, their circumstances are unique and they find it increasingly important to take actions that are a “right-fit” for their communities.

Given the range of differences, the need for community-specific approaches is clear:

- *A small rural health department may encounter a case of TB only once during a year. A large district may need to manage diagnosis and treatment for several hundred.*
- *Driving distance to the nearest health facility is a major factor in rural communities. If the number and type of health providers is limited, public health may need to be a clinical provider.*
- *Communities within health jurisdictions are very different, too. A nutrition program that works for one group may not be embraced by another group with a different ethnic makeup and different food preferences.*
- *The relative difficulty or ease of arranging community participation may vary considerably from one locale to another.*

begun to put their reports to work in setting priorities for the coming years.

It is important that community health assessments include an evaluation of environmental factors that can have profound effects on the health of the population. The majority of those completed so far have included such a review, and several of the local health jurisdictions that did not include environmental health issues are developing separate reports on the subject.

Development of reliable environmental health data is difficult. Environmental health programs have often been seen as having a different focus from the rest of public health—a perception that began with some narrowly defined job roles for environmental health specialists and the need to support them on a fee-for-service basis. This in turn led to data collection activities focused on services performed rather than health problems prevented.

There have been several recent efforts to develop environmental health indicators that can measure factors in addition to the extent of disease, death, or injury. These indicators include such measures as the number of complaints about restaurants, water supplies, or failing septic systems in the community. They may include measures such as the percent of a population served by water supplies meeting all regulatory requirements for bacteriology tests, chemical levels, and sampling frequency.

Local health jurisdictions and the Department of Health have been working in coordination with national efforts to develop appropriate and acceptable environmental health indicators, but deciding on a universally accepted set of such indicators is difficult. The local environmental health directors have recently agreed upon a set of proposed indicators that could be used in Washington in designing, implementing, and evaluating interventions.

The public health system in Washington state is moving toward a new approach to environmental health, with less reliance on regulation and fee-for-service and more emphasis on the core functions of assessment, policy development, and assurance. Local health jurisdictions and the Department of Health see environmental health as an important part of the public health team in all areas of core functions and will incorporate environmental health into the assessment process.

The process of working on an assessment has a powerful influence on the community. Many jurisdictions report positive changes as community leaders gather to consider health data, long before the assessment report is finished. New relationships form, and there is a growing appreciation of the power of collaboration in addressing community-wide issues. Community priorities may change or become strongly reinforced as new information is introduced, and the community may also find new ways of looking at familiar issues.

The Department of Health has dedicated staff time to helping local health jurisdictions carry out community health assessment. Assistance includes consultation on assessment methods, sharing skills and software programs for data analysis, arrangements for training, and referrals to

technical experts in biostatistics, health economics, qualitative data analysis, health systems analysis, and program evaluation.

Local jurisdictions are also able to provide an increased level of assistance to one another as they focus on community assessment. Regional meetings have been convened to share information and address emerging issues in health assessment. Newly funded partnerships support 15 collaborative efforts which are assessment-oriented. One example is a 21 county partnership in which Seattle-King County Department of Public Health is providing the others with an easy-to-use computer software program to carry out analysis of health assessment data. Another is a five-county partnership in which the partners meet regularly to agree on common data indicators and methods and adhere to a common way of gathering data and developing reports. Their work will result in a separate report for each county, but they will have saved time and enhanced skills by going through each step of the process together.

Report: *The Health of Washington State*

In September 1996, the Department of Health published *The Health of Washington State*, an objective appraisal of health in Washington state from three important perspectives: the health status of the people in the state, the major health risks they face, and the health systems that exist to protect, maintain, and improve their health. This work built upon the outcome standards and key public health problems in the 1994 PHIP.

The Health of Washington State focuses on about 50 health indicators in six different areas: infectious disease, non-infectious disease, violence and injury, family and individual health, environmental health, and health systems. The presentation includes discussion of time trends, geographic variation, and variation by age, gender, race, and ethnicity. It also includes a discussion of national and state year 2000 goals.

The report makes no attempt to rank Washington's health problems or communities. It does not set public health priorities, but rather aims to provide objective information for priority setting and policy-making discussions. Each section compiles available information about known risk and protective factors and high risk groups, and concludes with a discussion of interventions. The intent is to provide the best available information about where to intervene and what strategies work best.

While *The Health of Washington State* offers the most comprehensive and convenient resource for statewide health data, it is a complement to, rather than a substitute for, detailed local health assessments. It was designed to be generally consistent with the health indicators in the *Healthy People 2000* goals for the nation, and takes a systematic approach to providing a state-level overview using standard statistical methods. Information from *The Health of Washington State* and community health assessments will be the foundation for the *State Public Health Report* prepared by the state Board of Health.

The development of *The Health of Washington State* pointed out that the setting of long-range state health goals is an important policy activity

Public health on the web

As part of the INPHO project, the School of Public Health and Community Medicine at the University of Washington has created an on-line public health events calendar listing upcoming events such as training, seminars, conferences, and meetings. It can be accessed through the World Wide Web for both viewing and adding events.

The Northwest Center for Public Health Practice web site is at:
<http://weber.u.washington.edu/~nwcphp>

There are numerous other web sites of potential interest to public health professionals in Washington state, most of which have links to other sites. They include:

The School of Public Health and Community Medicine:
<http://weber.u.washington.edu/~sphcm/sphcm.html>

Washington INPHO:
<http://inpho.hs.washington.edu/index1.html>

CDC INPHO:
<http://www.cdc.gov/inpho/inpho.htm>

Washington Department of Health:
<http://www.doh.wa.gov/>
Northwest Portland Area Indian Health Board:
<http://www.teleport.com/~npaihb>

with no clear current locus of responsibility. The recommendations in Chapter 3 address this problem. The statewide report will be updated regularly and will undoubtedly change and improve over time. Local assessment reports will also continue to evolve in the years to come. The goal for the future is that both processes will develop a set of common core data and analytic standards that will facilitate the comparability and usefulness of the information generated at both the state and local levels.

The ABCs of INPHO

The Automated Birth Certificate (ABC) system is now available to local health jurisdictions that are fully connected to the Information Network for Public Health Officials (INPHO). DOH's Center for Health Statistics has completed a project to move the vital records system to a more efficient computer system linked to INPHO.

Utilizing the ABC system through INPHO will save both the state and local health jurisdictions money and will improve service to the public. Using ABC over INPHO, birth certificates are printed and available to the customer approximately 30 seconds after the information is entered into the system. This means no waiting or return visit for the customer and less staff processing time for the local health jurisdiction.

Information Network for Public Health Officials (INPHO)

The goal of the INPHO project is to give everyone working in public health in Washington the information they need at their fingertips. To facilitate this, the project is linking all local health jurisdictions with one another, the state Department of Health, the Centers for Disease Control and Prevention, and the Internet through an integrated, secure computer network. This network will greatly improve the public health community's ability to conduct outbreak investigations, disease surveillance, and notification of health threats. To date, 16 of the 33 local jurisdictions are connected through this system. The remaining 17 will be connected no later than September 1997.

Currently, all local health jurisdictions have access to e-mail and the Internet through the University of Washington. Four counties are now using the INPHO infrastructure to access the CHILD Profile immunization tracking system that maintains the immunization history of children under the age of six. There are also six counties using the network to access the state's Automated Birth Certificate system (sidebar).

The department is working to provide access to additional databases, including drinking water systems and hospital discharge data. Information from these databases will help local health jurisdictions assess health issues in their respective communities.

Geographic Information System (GIS)

The state Department of Health has installed a computer with a full capacity Geographic Information System and developed databases and map coverages which will be used to support health surveillance and assessment in a variety of program activities. One of the first uses of the system was to produce the maps in *The Health of Washington State*.

A GIS application is being developed which will allow public health investigators to quickly obtain and display rates of disease, hospitalization, mortality, and morbidity, and do queries to assess the presence of environmental hazards. The system will permit analysis at any geographical level in the state such as county, zip code area, census tract, legislative district, or a community or neighborhood as specified by the investigator, even if the defined area crosses city or county boundaries. The purpose of this application is to support and integrate Department of Health surveillance activities, extend the analysis to any relevant geography, and consider time trends.

It is anticipated that the Department of Health GIS will link with similar systems and health related databases in other agencies and with local governments. Eventually the GIS-based system will be interconnected with other agencies and local health jurisdictions through INPHO, and will serve as an important part of a decision support system for both policy makers and epidemiologic investigators.

Information Resource Management (IRM)

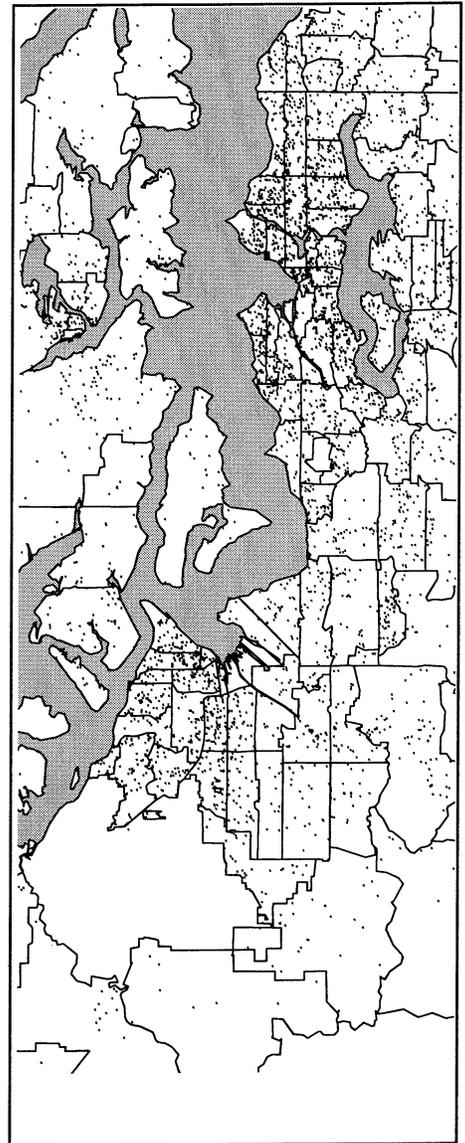
Key personnel from the Department of Health and several local health jurisdictions are participating in planning and designing a new process for managing the department's information resources. The department is defining its functions, processes, and activities as well as the information and technology needed to support them. The goal is to reduce redundant information collection and efficiently manage and share information within the agency as a whole and with other partners. This effort will look closely at the types of activities and informational needs that DOH divisions have in common and will build on them when developing a list of prioritized information technology projects. Although this effort focuses primarily on internal information systems, it will greatly improve the quality of data that the department will be able to share with local health jurisdictions and others.

American Indian Data Plan

The Department of Health and the American Indian Health Commission have collaborated to establish the American Indian Data Committee and to design an Indian-specific health information system that integrates tribal, state, and federal data that will support policy development to improve the personal and public health care and health status of Indian people. The committee includes members from tribes, urban Indian organizations, the Department of Health, the Northwest Portland Area Indian Health Board, the Department of Social and Health Services, the Governor's Office of Indian Affairs, and the Health Care Policy Board.

The committee has developed some recommendations that enable the state to create a framework for data sharing and standardization. The recommendation to establish an American Indian Data Clearinghouse is a first step in developing state and tribal capacity to consolidate existing American Indian health data and meet the intent and direction set forth in state law.

This work builds on the existing relationship between the Department of Health and the American Indian Health Commission. The data plan is linked to the American Indian Health Care Delivery Plan. Both the commission and the plan are discussed later in this chapter.



Cancer Deaths: Tacoma to Everett
In 1994 there were 9,904 cancer deaths in Washington. This map, made possible by GIS technology, shows the most populous part of the Puget Sound area. The lines are zipcode boundaries. Each dot represents a 1994 cancer death located with special geocoding technology in an exact latitude and longitude according to the deceased's residential address.

This technology can be used to study the spatial distribution of cancer deaths to help determine if there are associations with neighborhood characteristics or possible environmental hazards.

A regional approach to community health assessment

Five local health jurisdictions in the southwest corner of Washington have entered into a partnership for building the capacity to conduct community health assessment. Mason, Lewis, Pacific, Grays Harbor, and Wahkiakum counties received an eighteen month \$110,000 partnership grant in January 1996. With Lewis County as the fiscal lead, the group entered into a contract for technical assistance in analysis of population data and for training on data presentation to the community. The partners plan to pool resources for hiring an assessment coordinator and epidemiologist.

The availability of funding was the incentive for beginning this cross-jurisdictional collaboration. Each county is estimating a savings of \$25,000 in the next year by taking a collaborative approach to conducting community health assessments. For a very small county such as Wahkiakum, finding the resources on its own for health assessment may not have been possible. By taking a regional approach, each local health jurisdiction will have increased awareness of how their county's health resources and risks compare. Based on the relationships that have been built through the assessment activity, there will be opportunities in the future for collaborative prevention strategies that address regional health issues.

Improving collaboration among many partners

Principle: Collaboration between governments, communities, organizations, and individuals is necessary to improve the health status of the population.

How can health problems be prevented in our complex society? Which organizations should be working together to intervene when problems exist? Can partnerships lead to more efficient use of limited funding and other resources? What are effective incentives to bring governments and organizations together to create healthier communities? How can public health best respond to the changing health care system?

A collaborative approach involves building relationships, establishing effective communication, and sharing resources with many diverse partners, including state and local public health jurisdictions, community service providers, business, labor, health care providers, insurance plans, and others. Though it often takes more time initially than independent action, the public health system is finding collaboration to be an effective and efficient way of doing business. Sharing resources to strengthen the functioning of the public health system has been an important method for PHIP implementation. In the past two years the state Department of Health and local health jurisdictions have developed and are participating in new partnerships and coalitions in taking a collaborative approach to improving the public's health.

Public health partnerships

The 1994 PHIP recommended that the state provide financial incentives to encourage collaboration among local health jurisdictions and other community-based agencies and organizations. The Department of Health and representatives of the Washington State Association of Local Public Health Officials considered how to create financial incentives for collaboration. Twenty percent of the 1995-97 Local Capacity Development Funds, approximately \$1.1 million, were designated for building public health partnerships.

The PHIP Steering Committee approved principles to guide the Department of Health's dissemination of the partnership funds (see sidebar, next page). The steering committee recommended that the department set criteria for selective distribution of the funds and that partnerships be evaluated for their effectiveness in building capacity that can be sustained with other resources in the future.

Most public health partnerships represent a significant effort to establish some public health capacity on a regional basis rather than jurisdiction-by-jurisdiction. Without making any changes in governance structure, local health jurisdictions are making more effective use of new funding by sharing resources such as professional staff, training, and information

systems. Early evidence suggests that for smaller local health jurisdictions, regional capacity building will prove to be a cost effective approach.

In two funding cycles, the Department of Health funded twenty partnership projects involving 25 local health jurisdictions, eight Indian tribes, and several community organizations. The distribution of funds was limited by statute to local health jurisdictions that submitted proposals for either local or regional collaborations. The partnership projects represent a variety of activities and collaborative models. The primary purpose of the partnership projects is to build sustainable core function capacity at the community level. Appendix D has more detail about individual projects.

The Department of Health will evaluate the public health partnerships in three areas:

- 1) How well did each partnership achieve their project objectives?
- 2) Are partnerships an effective and efficient strategy for developing sustainable core function capacity?
- 3) Are partnerships an effective means to stimulate collaboration between local health jurisdictions and a variety of community and governmental partners, including Indian tribes?

It will take further analysis, as information becomes available, to determine the effectiveness and efficiency of partnerships in developing sustainable capacity—particularly regional capacity rather than local health jurisdiction specific capacity. The same can be said for evaluating the impact of the partnership strategy on relations between local health jurisdictions and Indian tribes.

Providing clinical personal health services

Local public health jurisdictions are examining their role in providing or assuring access to clinical personal health services in light of the rapidly changing health care environment. The decisions they face reflect the larger issues facing public health: how to create viable health systems, how to make sure the entire population is healthy, and how to sustain clinical services as a core of health protection.

To successfully address these issues, each local health jurisdiction must find ways of developing partnerships with other community providers. Recognizing this need, the Department of Health contracted with the University of Washington Health Policy Analysis Program and the Washington Association of Local Public Health Officials to assist local health departments and districts as they determine how best to assure the availability of clinical services. This effort is called the Clinical Personal Health Services Technical Assistance Project. Between January and October 1995, the project team visited eleven local health jurisdictions across the state—one-third of all jurisdictions—and talked to more than 200 staff, community health providers and organizations, and local elected officials. The sites visited were selected to provide

Public health partnerships

The PHIP Steering Committee recommended the following principles to guide public health partnership funding distributed on a selective rather than per capita basis to local health jurisdictions.:

- *Partnership funds are intended to increase the efficiency of the public health system through collaborative capacity building strategies.*
- *Partnership funds are an incentive for developing new and/or enhanced core function capacity.*
- *Partnership funds are available for collaborative ventures between local health jurisdictions and a variety of governments, tribes organizations, and agencies.*
- *Partnership funds are intended to provide time-limited and partial support for core function activities.*

Examples of partnerships include:

- *The Snohomish Health District and the Tulalip Tribes are jointly developing and funding health promotion programs for Indians living on that reservation or using the Tulalip Health Clinic.*
- *The Northwest Partnership, including the San Juan, Island, and Skagit Health Departments, is establishing regional epidemiological services to enhance health assessment and disease surveillance capacity.*
- *Four small local health jurisdictions in the southeastern corner of the state (Asotin, Columbia, Garfield, and Whitman) are jointly strengthening and standardizing their accounting system and sharing a local health officer.*

Collaboration on immunization

In Clark County, the Southwest Washington Health District worked closely with the medical care community to assure provision of immunization services. The health district is providing fewer direct immunization services, but has assigned staff to work with private providers to train medical care staff, to assure that the vaccine is stored and used properly, and to assure that proper immunization schedules are maintained.

The success of this effort by the Southwest Washington Health District depended upon developing a strong and credible relationship with health care providers. While the health district slowly relinquished responsibility for the direct provision of immunizations, it expanded its community based quality assurance role. This local health jurisdiction is working with interested parties to consider privately-based options for the provision of current health district clinical services programs in ways which will improve access, contain costs, and improve health status.

balance between urban and rural, small and large, and eastern and western Washington departments and districts.

The project identified several key factors important to successfully identifying the proper balance of public and private clinical personal health services:

The role of local health jurisdictions in facilitating community discussion about direct provision of clinical personal health services.

Public health jurisdictions, alone, cannot have as much positive impact on health as can be achieved by combining their resources with those of other organizations. Local public health jurisdictions can facilitate discussions that elicit important perspectives from the health care system, private business, social service agencies, the criminal justice system, schools, and grassroots organizations. When community members participate in defining the health jurisdiction's role in the provision of clinical services, the outcome is often creative, meets the needs of the community, and is widely accepted as appropriate. Public health leadership within the community is essential to assure that all interested parties participate in the discussion of health care access.

The role of the health officer. A community served by a strong public health officer benefits from improved communication and collaboration with local providers. The health officer is in a unique position to become a recognized spokesperson for public health and a respected liaison between the local health jurisdiction and colleagues in private practice. In communities where health care providers have viewed the local health jurisdiction as a provider of clinical services, the health officer can be effective in forging closer alliances with other providers and in moving the health jurisdiction's role to a broader population-based focus.

Relationships in the community. Changes in the health care system are presenting challenges to the dialogue and collaboration central to the *Public Health Improvement Plan*. In the Washington communities that took part in the project, organizations and elected officials alike expressed uncertainty about the quality of care in the evolving health care system, and the accountability of the system to the community it serves. The programs providing health coverage—the Basic Health Plan, Healthy Options (Medicaid managed care), and others—should continue to participate in the dialogue regarding the provision of clinical personal health services.

The capacity of medical care providers to absorb services. The Healthy Options program, in particular, serves people who might once have routinely turned to a local health jurisdiction for some clinical personal health services. Many local health jurisdictions are developing collaborative relationships with private providers to share their public health expertise in working with high risk families. In addition to specific collaborations, communities need to assess the overall breadth and adequacy of managed care programs when deliberating the role of the local health jurisdiction in providing direct clinical personal health services.

During the course of the project, the team members discovered common issues in all the communities they visited. As a result, they developed a checklist for local health jurisdictions to use to assist them and their partners in determining how clinical personal health services should be provided. The "Critical Questions Checklist" presents four areas of evaluation: the current role of the local health jurisdiction, community information, community capacity for service provision and insurance status, and the preferred future role for the local health jurisdiction. Working with the checklist can facilitate the gathering of necessary information to support the decision about how a community will provide clinical services. The process can also be used with local boards of health and potential financial supporters for the jurisdictions to discuss the vision of the local health jurisdiction's future role. (See Appendix M for more information on the checklist.)

Education and training

The Department of Health, local public health jurisdiction leaders, and education professionals at the University of Washington have worked for the past two years to address both immediate and long term education and training needs of public health professionals. One result was the development of an introductory course on the core function approach for public health professionals, including a series of training modules designed to offer instruction and practice in using this approach to meet job responsibilities.

Between December 1994 and August 1995 1,340 public health professionals—about half of the statewide workforce—attended this four-day program. For those who were unable to attend the original program, a team of local and state public health professionals can provide customized, one-day training programs. This training is also being refined to meet the needs of new public health staff.

The Department of Health has developed a training series designed to improve the skills needed to facilitate community involvement—an area that was highlighted as a need by several local health jurisdictions when they completed the core functions performance survey. (See discussion beginning on p. 34.)

To establish a more comprehensive approach to training and education, the Department of Health, local public health jurisdiction leaders, and the University of Washington have agreed to jointly broaden the capacity of the Northwest Center for Public Health Practice—a new partnership approach to using an existing resource. The center has been redesigned to address multi-organizational needs and is co-directed by a local health jurisdiction health officer and a representative from the national Centers for Disease Control. The commitment from these organizations allows the Northwest Center to draw on each of their resources and provide more comprehensive education opportunities than were possible prior to restructuring.

Alliance to improve health status

In 1994, as a result of a grant submitted by the Whitman County Health Department, the Whitman County Alliance for Health and Human Services was formed. The alliance includes representatives from the local hospitals, the health department, child protection services, the council on aging, and the business development association, among others. The purpose of the alliance is to improve the community's health status by bringing together the various community agencies and organizations, improving interagency cooperation and trust, sharing information, and learning about each other's resources. The health department played a critical role in the leadership of the alliance. Their involvement provides an excellent example of the role public health can have as a community catalyst.

Tribal culture and health

Mainstream health services are sometimes ineffective with many Indian people. The tribes' goal is to deliver medical care and other health services within the social and cultural context of their communities.

For example, since 1992, the W.K. Kellogg Foundation-funded Lummi Cedar Project, in collaboration with the Lummi Indian Nation, the Whatcom County Health Department, and the University of Washington, has promoted public health through their "Xwlemi Sche-lang-en" (Lummi way of life) canoe culture. Canoe pulling is important on both symbolic and practical levels to the Lummi culture. The elders hold the vision that through the harmony of perfect stroking they can achieve complete unison. The idea of harmony and unison is the basis of Lummi spiritual and community life. Perfect stroking teaches the art of canoe pulling and teamwork. Many expectations, such as excellence in physical and emotional health, and sobriety, are placed on those who participate.

The Healing Lodge of the Seven Nations, located in Spokane, is another example. Governed by seven tribes east of the Cascade Mountains including Washington's Colville, Kalispel, and Spokane Tribes, it uses a holistic and traditional American Indian approach for treatment of chemically dependent youth.

One of the center's first projects has been a collaborative effort with local health jurisdictions to develop a workshop on strengthening public health administrative capacity. The center is also independently developing short courses on specific health issues such as assessing the immunization rates of children. The center will be taking the lead in further developing the INPHO system—asking public health professionals what kind of information they need, getting that information on-line, and helping public health professionals find and use the information they need.

Over the past two years, the Northwest Center has also participated in developing a comprehensive description of the skills and knowledge that public health professionals need to meet the core function performance standards (the Public Health Improvement Plan Education and Training Competency Model). This description is available for local public health leaders to use for organizational in-service training. It will be a foundation for further training developed by the center and will be used as one of tools guiding public health curriculum changes in the University of Washington's Department of Health Services. The intent will be to incorporate the core function approach into the curriculum and make it more practice-oriented. See Appendix K for more information on PHIP-related reports.

American Indian Health Commission for Washington State

In addition to maintaining direct relationships with each of the tribes in Washington as established by the Centennial Accord of 1989, the Department of Health collaborates with the American Indian Health Commission for Washington State (see Appendix H). Established in 1994, this consortium of federally recognized tribes, urban Indian health programs, and individual American Indians and Alaskan Natives has played a pivotal role in opening communication with the Department of Health and other state agencies. It serves as a forum to communicate with a united voice on health-related issues and to negotiate policy formulation with state agencies.

Working with the Department of Social and Health Services, the commission integrated Indian health programs into the Healthy Options Medicaid program and worked with the Mental Health Division to address Indian health programs in the Community Mental Health Program waiver providing Indian choice.

Working with Washington Health Care Authority (HCA), the commission has encouraged HCA to expand tribal sponsorship in the Basic Health Plan (BHP) and made sure HCA developed models in order to further market the BHP to American Indians in Washington.

Working with the Department of Health, the commission has conducted an assessment of core public health functions performed by the tribes, created the American Indian Data Committee to develop an American Indian specific data plan, and developed a definition of Tribal Health Jurisdiction for the department and the commission to analyze.

It is the commission's policy to seek consensus and provide guidance to the state regarding the collective needs of its members to assure quality

and comprehensive health care to Indian people in Washington. The commission does not circumvent the sovereign authority of the tribal governments. It coordinates an annual Tribal Leaders Health Summit.

American Indian Health Care Delivery Plan

The 1995 Legislature, in the Public Health Improvement Act, gave the Department of Health responsibility for overseeing and supporting the development of the American Indian Health Care Delivery Plan. The department, working in collaboration with the Indian health services system and providers in Washington, is responsible for developing a plan which includes:

- 1) Recommendations to providers and facilities regarding methods for coordinating and joint venturing with various Indian health services for services delivery.
- 2) Methods to improve American Indian health programming.
- 3) Recommendations for collaborative funding and service delivery opportunities for the unmet health needs of American Indians.

A 16-member advisory committee has been appointed, comprised of representatives of tribes, an urban Indian health program, the Northwest Portland Area Indian Health Board, a local public health jurisdiction, the Washington State Hospital Association, a state senator, the Department of Health, the Department of Social and Health Services, the Health Care Authority, the Health Care Policy Board, and the Governor's Office. The American Indian Health Care Delivery Plan will be submitted to the Legislature in June 1997.

Community Public Health and Safety Networks

Community Public Health and Safety Networks were created by 1994 legislation to develop and carry out community-based action plans to reduce and prevent youth violence. The state Department of Health and local health jurisdictions have played important roles over the past two years in developing the network plans.

The Department of Health provided two editions of a "Youth Risk Assessment Database" to each network as well as analyzing and reporting research on child abuse and other risk and protective factors. In collaboration with local health jurisdictions, the Department of Health developed assessment and policy development criteria for the local health jurisdictions to use in their review of the plans. As a member of the Family Policy Council, the Department of Health has reviewed all network plans and evaluated them for potential impact on state agency policy.

Local health jurisdictions have participated with networks as both community agencies and in some cases as a member of their governing board. Staff have provided technical assistance in data gathering and interpretation which contributed to the information-based decisions reflected in the network plans. In the future, networks can help local

Sea-King's work with the Greater Issaquah Network

The Greater Issaquah Community Network is one of seven community networks in King County. It includes a diverse mix of suburban and rural areas of eastern King County. The network found that much of the available state data did not match their unique geographical jurisdiction, and thus could not serve as a starting point for creating the comprehensive prevention plan.

The Seattle-King County Department of Public Health (SKCDPH) provided technical assistance in the form of training on how to deal with data limitations as well as some additional data pertaining to some of the communities within the Greater Issaquah Network. The network planners then had a sufficient foundation to begin the process of meeting with community groups and identifying their priorities. That experience opened the door for them to do a community and provider survey involving 1200 citizens, including 600 youth, to capture the "community voice" from other sources.

The SKCDPH staff felt confident that they had contributed to a strong community process which produced ownership for the prevention plan. The staff also came away from this experience with better skills in collaborating with their community.

A public health coalition

The Lincoln County Health Department had problems in 1992. Their building was too small and out of compliance with standards in the Americans with Disabilities Act. Retaining qualified staff was difficult with the low county wage scale, and local government funding for public health had been declining for 10 years.

The health department initiated a series of meetings between the local health board and the two public hospital district boards. Benefits of collaboration were identified and a commitment upheld to address the community's public health concerns. In 1993 the Lincoln County Public Health Coalition formed and in 1995 negotiated an interlocal agreement with the county and the hospital districts. The new organization, in carrying out its public health responsibilities through a collaborative approach, found securing new grant funds to be easier. The community was actively sharing in finding solutions to the identified concerns. The coalition has been successful in expanding access to health screening with a mobile clinic, has recruited qualified staff, and moved into a new building with modern equipment. Collaboration continues to be the approach in working with the community, as the coalition reaches out to organizations such as Northwest Health Partners and the Columbia Basin Regional Health Network to address health access problems in rural eastern Washington.

health jurisdictions mobilize communities for setting local priority health issues.

Improving accountability

Principle: Accountability for the results of decisions and actions in the public health system is essential to make the best use of limited resources.

What are the measures of an improved public health system? Does the financing structure of public health assure accountability for improving organizational capacity and health outcomes? Does the governance structure identify who is responsible for protecting all Washington residents from health risks? Who has responsibility for monitoring the quality of the health care system?

These questions all address one of the most important features of the PHIP—accountability. Setting standards and measures for improvement has received a great deal of attention in the past two years. The PHIP Steering Committee has also examined the financing of public health and recommended changes. This section reports on gains that have been made in achieving greater accountability for the public health system's effective use of resources.

Governance of public health in Washington

Accountability to protect and improve the public's health rests at the federal, state, and local levels of government. The governance structure defines the relative authority, responsibility, and functions that levels of government have for assuring conditions that are conducive to people's health. The primary authority is at the county level where local boards of health, comprised mainly of local elected officials, oversee local health jurisdictions. The state has responsibility, through the power of the Department of Health Secretary and the State Health Officer, to step in if a local jurisdiction is not adequately meeting its responsibilities of protecting the public's health. Guidelines for the local health jurisdiction responsibilities are listed in WAC 246-05. The PHIP Steering Committee recommends a review of those responsibilities for inclusion of the core function approach. For a complete description of the public health system and its governance, see Appendix A.

Tribal authority for public health currently is not defined in state law. Without clarification of tribal authority, a gap exists in the protection of all residents in Washington state. There are 27 federally recognized tribes in Washington State, occupying Indian territory and land that vary greatly in the terms of geography, resources, and population (see map, Appendix A). The 1994 PHIP recognized the sovereign authority of tribes "to determine their own capacity standards; set urgent public health priorities; and carry out core public health functions." Current

laws and regulations, however, do not address the gaps in public health protection that arise due to tribal sovereignty. They do not adequately deal with the fact that local health jurisdictions do not have jurisdictional authority for Indian territory and land. As a result, financing and delivery of public health services on Indian territory and land are often fragmented and, in some cases, incomplete.

The PHIP Steering Committee recommends future work to resolve this dilemma by examining a proposed definition for tribal health jurisdiction. There are also a number of other activities the tribes are engaged in to improve health care delivery and public health protection for tribes. Many of these activities are occurring through the American Indian Health Commission. For a detailed discussion of tribal health issues see Appendix H.

Financing of public health in Washington

The public health system is improving accountability for using the available resources wisely. The answer to the question of “who should pay for public health” is complicated and changes over time. The funding of public health varies significantly between local health jurisdictions by amount and by which activities are funded. This section gives some important background information about public health financing and presents recommendations for improvement.

The history of public health financing in Washington reflects a series of historical responses to specific situations in local communities and across the state, rather than systematic development according to any established principles. Multiple and variable funding streams currently support public health activities at the state and local level.

County government has the primary authority and responsibility for determining how the public’s health will be protected; it also has the primary responsibility of determining how local health jurisdiction activities will be financed. Local support, from the contributions of county and city government and from the collection of fees for services, has traditionally been larger than either state or federal support.

The 1994 PHIP recommended that in order to develop and sustain the capacity to carry out the core functions, the public health system needed an adequate level of funding from dedicated sources. Funding must be tied to stable sources of revenue that can grow in proportion with the population and be flexible for responding to local community needs and concerns.

Financing principles: A focus of attention for the PHIP Steering Committee has been to develop recommendations designed to assure that financing policy supports effective use of existing and future public health resources. Studies of public health financing streams have found an overall statewide lack of coordinated and systematic decision-making. Contributing to this problem has been the absence of a consistent framework to guide or influence financing decisions.

Tribal sovereignty and jurisdiction

Tribal sovereignty, the right of an Indian Tribe to govern its territory and members free from most state laws and authority, creates complex jurisdictional issues for state and tribal governments.

Complicating jurisdictional issues is the “checkerboarding” of land within the reservation boundaries, where some land may be owned by the tribal government; some land is held in trust for the tribe by the federal government (“trust land”); and some land is privately owned (“fee land”).

Jurisdictional authority to apply and enforce laws and regulations, and to collect taxes, tends to follow four general rules:

- 1. State and local governments have very limited jurisdiction over Indians on reservation or over Indians who are exercising treaty rights off reservation. (e.g. treaty-protected fishing)*
- 2. Tribes have little or no jurisdiction over non-Indians off reservation.*
- 3. Tribes have some jurisdiction over non-Indians who live or work on reservation.*
- 4. In some instances, tribes may have some jurisdiction over “fee lands” including those owned by non-Indians.*

Accountability for safe on-site sewage disposal

In Washington state, 42% of the population is served by some type of on-site sewage system; the remainder of the population is served by municipal sewers. The Department of Health's on-site sewage program is working with local health jurisdictions on several activities to assure safe disposal of sewage.

- *Development of program standards for local on-site sewage programs to address program services, activity levels, and capacity such as recommended staffing levels based on permit work load.*
- *Creation of a Wastewater Advisory Committee to assist in the development of policy and direction of the program in future years.*
- *Development of program indicators, which differ from program standards. Standards measure program activity. Indicators, such as population exposed to sewage or number of illnesses resulting from such exposures, will provide health risk and health outcome baseline information now, and ultimately allow the measure of health outcome trends.*
- *Development of program evaluation tools, including self-audit tools, data management capability, and mechanisms to feed this information back into the program assessment tools (program standards and program indicators).*

The PHIP Steering Committee developed a set of Public Health Financing Principles (see Appendix E) that can serve as guidelines for state and local government financing policy. They are broad statements intended as a starting point for consideration of long-term state and local financing decisions. They cover the topics of public benefit, stability of financing, incentives for efficiency, and equity of opportunity for basic health protection.

The financing principles are based on three assumptions:

1. State and local government have a shared responsibility, along with the individual and community, to protect and promote the public's health.
2. A well functioning public health system requires an adequate base of support from state and local government.
3. A fundamental level of capacity is needed throughout the state for carrying out the core public health functions.

The PHIP Steering Committee recommends that state and local government use these principles for setting financing policy that determines how public health activities are funded and how funds are distributed.

Local financing of public health

Consistently over the past 20 years, local support has comprised over half of the total spending of local health jurisdictions in Washington state. This local support has three components: county government financing, city government financing, and service charges in the form of fees and permits.

County government financing: In 1995 there was wide variation in both the per capita level of local government support for public health activities and in how the funds were spent. Per capita annual local support of local health jurisdictions varied from a high of \$31.45 to a low of \$5.05 among jurisdictions in Washington state. (These figures reflect combined county and city support.)

Currently, there is no agreed-upon base level of county government funding for public health. Local health jurisdictions need an adequate county base of financing support for establishing and maintaining the infrastructure to perform the core functions for assessing health risks and providing fundamental levels of protection and prevention.

City government financing: Before 1995, cities and towns contributed a negotiated amount, guided by formulas in WAC 246-05-020, to go to the local health jurisdiction. Each city and town was obligated to contribute to the local health jurisdiction or to establish their own health department.

The Health Reform Act of 1993 proposed financing changes which were implemented through the passage of SSB 6058 in 1995. A financing mechanism for cities' and towns' contributions to public health was established through creation of the county public health account made up of 2.95% of the state Motor Vehicle Excise Tax (MVET). That share of

the MVET had previously been distributed to cities and not dedicated to local public health. Starting January 1, 1996, MVET revenue was distributed to local health jurisdictions based on the 1995 city and town contribution level. With negotiation, some cities and towns are continuing to make contributions to public health in addition to the base level from the MVET.

Fees: Direct charges to the consumer in the form of fees for services and permits have become a common and necessary source of revenue for local health jurisdictions. Local government, through the actions of the local board of health, has authority for decisions about which services are to be supported by fees and the level of that support.

Fees for services and permit functions have consistently made up about one-fifth of total local health jurisdiction revenues. Many fee-supported activities with population-based benefits are subsidized with local public funds.

To better understand the reasons behind the variation in how local health jurisdictions handle fee issues, the Department of Health surveyed all 33 jurisdictions in September 1995. The survey resulted in the "Local Health Jurisdiction Fee Report", which pointed out the need to move toward more uniform methods of calculating service costs and for some guidelines on how local boards of health could approach the complex task of establishing fees and subsidy levels for the multiple activities of a local health jurisdiction. The PHIP Steering Committee, recognizing that setting fee policy is the authority of local government, approved a set of principles for guiding the discussion and decision-making that goes into creating and revising the local health jurisdiction fee schedule. The "Fee Principles for Local Health Jurisdictions" are in Appendix E. This is a companion document to the previously discussed Public Health System Financing Principles.

The state Department of Health developed descriptive instructions for local health jurisdictions to use in calculating actual costs of service provision and in the step-by-step process of establishing a fee schedule. These instructions became known as the "Fee Tool Box" and were approved by the PHIP Steering Committee for distribution to local health jurisdictions in June 1996.

State financing

Until the late 1980s, Washington state provided relatively little funding for local public health. With passage of the Omnibus AIDS Act of 1988 and the formation of the state Department of Health in 1989, state funding of local health jurisdictions increased but still remained below federal and local funding levels.

Local Capacity Development Funds. A major development in state financing occurred when the 1993 Legislature allocated \$10 million for the 1993-95 biennium for local health jurisdictions on a per capita basis. Following the recommendation of the 1994 PHIP, the Legislature approved an additional \$4.75 million for the 1995-97 biennium to

Public benefit and public funds

All public health activities have some degree of public benefit. Some, such as infectious disease investigation and monitoring of drinking water supplies, have population-wide benefits.

Others, such as certification of food handlers and immunization against communicable diseases, have a mix of both individual and public benefit.

Public benefit is an important consideration when determining the financing sources for the various public health activities. Traditionally, activities which to some extent directly benefit an individual or organization have been either partially or fully supported by fees, while activities that directly benefit the public are supported by government funds. Complicating this financing picture is the inability of many individuals to pay for needed services.

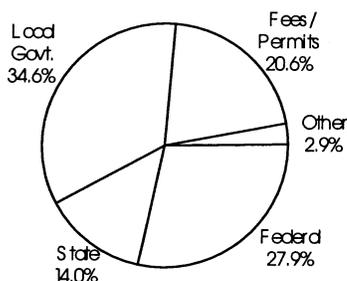
The Public Health System Financing Principles and the Fee Principles for Local Health Jurisdictions (see Appendix E) use public benefit as a key consideration in financing decisions.

**Public health funding:
Three key points**

1) *Based on state and national estimates, public health expenditures are about 2 to 3 percent of total annual health system spending, most of which goes for illness care.*

2) *Over the past 10 years Washington state government has increased its investment in local public health. In 1985 state revenues comprised 2.2% of total local health jurisdiction revenues; by 1995 the state share had increased to 14%.*

1995 local health jurisdiction revenue, by source



3) *There is a wide variation in per capita level of county and city government support for local health jurisdictions. In 1995 per capita county and city funding of local health jurisdictions varied from a high of \$31.45 to a low of \$5.05. That variation is due to a number of factors including differences in local tax base, fee-for-service policies, the selection of services and programs provided, and severity and degree of health problems and risks.*

increase local health jurisdiction capacity. This new state funding in the past two biennia, which could be used for locally set priorities, is called the Local Capacity Development Fund (See Appendix D for detail).

Before 1993, state funding to local health jurisdictions had been almost exclusively “categorical”—to be used for specific services or problem areas. Local Capacity Development Funds give much greater flexibility and allow local health jurisdictions to fit funding to the unique issues, concerns, and priorities of individual communities.

Existing law (RCW 43.70.58) prohibits the supplantation of local revenues with the Local Capacity Development Funds. Given the lack of a defined local base of support for public health and the multiple sources of local health jurisdiction financing, supplantation has proven very difficult to document. The PHIP Steering Committee recommends that future distribution of LCDF be tied to a defined county base of public health support.

Federal financing

Federal financing of local public health consists primarily of revenue from categorical grants and reimbursement for Medicaid eligible services. The categorical grants have had an impact on critical public health problems such as chronic diseases and childhood communicable diseases, and are often consistent with local health priorities. The state Department of Health is, in most cases, the administrator and distributor of federal funds to local health jurisdictions.

The flexibility of federal funding coming to the state through federal grants was documented in a 1995 report, “Use of Federal Public Health Funds in Washington State,” prepared by the University of Washington Health Policy Analysis Program. The report pointed out that it is possible for the Department of Health to shape the federal grant processes to fit local and state priorities. The Department could move beyond the program-specific, “categorical” nature of federal public health grants by articulating a clear vision of a broader use of the funds and negotiating assertively with federal administrators. The PHIP Steering Committee recommends that DOH continue to explore flexibility of federal funds to maximize their use in building public health system core function capacity.

Measuring capacity and core function performance of local health jurisdictions and tribes

Population-based health services are an essential component of the overall health system in Washington state. Public health has the primary responsibility for providing leadership in developing and assuring population-based services through the core function approach discussed throughout this report. These functions, when carried out with the involvement of the community, are expected to contribute to improving the health of Washington state residents. For example, community health

assessments and policy discussions about priority health issues have been shown to result in new collaborative efforts to address those priorities. These collaborative efforts take a variety of forms, from sharing organizational resources that support population-based health services to creating new delivery mechanisms for clinical personal health services or improved procedures for assuring the availability and quality of health services. Whatever the form, the process and results of organizational changes and partnerships must be monitored and evaluated to ensure that public health is moving continuously forward toward the goal of improving the health status of Washington residents.

The 1994 PHIP and the 1995 Public Health Improvement Act both call for the public health system to develop a method for measuring the system's capacity to perform core functions—that is, to measure the organizational strengths and weaknesses (*capacities*) of local health jurisdictions and the state Department of Health in their ability to perform a basic set of activities (*core functions*) that result in improved health status. This requirement is one important piece of the PHIP's long range approach to improving health.

Developing the measurement tool

In 1994 the first *Public Health Improvement Plan* defined what the public health system must *do*. The 88 core function capacity standards identified specific responsibilities that state and local public health organizations must assume. (Appendix G lists the revised Core Function Capacity Standards.) The 1994 PHIP did not, however, identify what *capacities* those organizations must have to effectively carry out this core function approach. A survey of national literature revealed that none of the previous efforts to measure public health core function performance addressed the array of issues raised in the 1994 PHIP. Because of the complexity of the undertaking, and the requirements of the Public Health Improvement Act, a decision was made to concentrate first on developing a tool to measure local health jurisdictions' capacity and core function performance. Like the development of the core function capacity standards themselves, developing a tool to measure the ability of local health jurisdictions to carry out the core function approach was entirely original work.

A critical step in developing this performance measurement tool was clarifying distinctions between the concepts of "capacity" and "core function". (See sidebars for definitions.). Four major organizational capacity elements were identified as necessary for local health jurisdictions to effectively carry out the core functions of assessment, policy development, administration, prevention, and access and quality. These four capacity elements are:

- The presence of supportive organizational structures and policies.

What does it mean to perform core functions?

Assessment results in ongoing monitoring and determination of causes of health problems, routine collection of health data, timely investigations of outbreaks, and a system to disseminate information in a useable form to community leaders, health providers, and the general public.

Policy Development results in community coalitions and support to prioritize community health issues, and a community-based system to prepare, approve, implement, evaluate, and disseminate policies.

Administration results in effective operational policies, strong public health leadership in the community, long term financial and personnel management plans, and accountability for the use of resources.

Prevention results in the coordinated delivery of both population-based and clinical personal health services in the community, written strategies to reduce exposure to health risks and disease, and a community plan to control threats to the public's health.

Access and Quality results in collaboratively developed strategies that lead to improved quality of health care and increase access to health services in the community.

What are capacities?

Capacities are the organizational characteristics that must be in place to effectively carry out the core function approach to improving health. In the 1996 local health jurisdiction and tribal surveys they are defined as follows:

Structure and Policies

The public health jurisdiction has clear lines of authority, organizational structure, and procedures needed to effectively carry out core functions. (Does the jurisdiction have the necessary authorizations and operational policies in place to improve core function performance?)

Skills and Resources

The public health jurisdiction has the workforce, financing, facilities and equipment required to effectively carry the core functions. (Does the jurisdiction have the personnel, financing and other resources needed to improve core function performance?)

Information and Communication

The public health jurisdiction can receive, process, and communicate information, data, and reports to effectively carry out core functions. (Does the jurisdiction have access to relevant information, can we process and disseminate findings to improve core function performance?)

Community Involvement

The public health jurisdiction has processes in place to collaborate with the public it serves, with the officials it represents, and with the health providers with which it practices to effectively carry out core functions. (Does the jurisdiction have the ability to influence and integrate core function performance in the community?)

- A skilled workforce equipped with necessary resources.
- An effective information and communication system to serve both external and internal constituencies.
- An active involvement with the general public, community providers, and elected officials.

Separating the concepts of “core function” and “capacity” allowed for the development of a multi-dimensional tool—a matrix format—which could be used to measure the current status of both with a manageable number of indicators. The measurement tool itself consists of four matrices—one for each of the capacity elements that relates it to all five core functions. (The matrices and graphic summaries of survey results are in Appendix F.)

Survey of local health jurisdictions

In June 1996 the measurement tool was sent to all local health jurisdictions. Twenty-eight (85%) of the 33 local health jurisdictions returned their responses to the state Department of Health. These serve over 95% of Washington state residents.

In their initial use of this tool, local health jurisdictions have confirmed that the standards and indicators accurately describe and measure their core function responsibilities and capacity needed to perform them. Results of the survey indicate that:

- The core functions of Prevention and Administration are being performed at a slightly higher level than Assessment and Policy Development. The Access and Quality function is rated at a much lower level. (Appendix F, Figure 1) This result is most likely due to the fact that these are combined in the definition of core functions, but in practice cannot be measured with the same indicators. Many local health jurisdictions indicated that it is difficult to determine one score for two very distinct functions. This is a significant result and is the basis for recommending that “Access” and “Quality” be separated into two core functions.
- The capacity of Structure and Policies is the most fully developed element. It is followed, in order, by Skills and Resources, Community Involvement, and Information and Communication. (Appendix F, Figure 2)

Using the results of the local health jurisdiction survey

In considering the general findings of this first survey, it must be understood that no single statement is going to be accurate for all the 33 local health jurisdictions. However, the aggregate survey results do have implications for how the Department of Health and local health jurisdictions can direct their existing and future resources.

As local health jurisdictions identify their organizational strengths and weaknesses, community needs, and opportunities, they will use this

information for organization development, planning, and budget decisions. Both local jurisdictions and the state Department of Health can identify training, technical assistance, and other resource needs for public health personnel. Several professional skills have already been identified and defined based on the standards of performance developed for the core function performance measurement matrix.

Improving the ability to evaluate public health system effectiveness

Developing and testing the measurement tool has provided insights into what steps are needed to do a better job of identifying the strengths and weaknesses of the public health system.

- The testing process demonstrated that the original core functions framework of “Access and Quality” cannot be accurately measured unless these concepts are separated. Separate performance standards and indicators must be developed and tested for “access” and “quality”. This process will help to better identify the relationship between local health jurisdictions and the medical care system and identify the level of capacity needed to perform the core functions in light of this relationship.
- The measurement tool’s reliability and validity should be refined through a combination of scientific, academic, and external community review. The community review will elicit a more objective picture of a local health jurisdiction’s effectiveness as a reliable source of health information and center of community mobilization to address health issues. This review will also provide the critical link between what a health jurisdiction does and its impact on the community. Preliminary work has begun to identify public health core function “products” that will be both visible to, and valued by, the community.
- Using the procedural framework established for local health jurisdictions, the state Department of Health should develop measurable core function performance indicators based on its specific responsibilities within the system of public health. This will result in a more complete picture of system-wide capacity and performance.

This measurement tool should also be used to support other activities designed to improve the accountability of the public health system.

- Although this measurement tool is not primarily intended to be an instrument for contracting between local health jurisdictions and the Department of Health, the information gathered about local capacity needs should be used as a basis for contracting focus and accountability.
- Local health jurisdictions and the state Department of Health should use the core function performance measures framework to develop best practices guidelines as one more step in linking public health system capacity to improved health status. (“Best practices” are defined as those methods that are most effective in achieving a desired outcome.)

Federal efforts in accountability

The federal Department of Health and Human Services (DHHS) will be requiring performance measures as part of the proposed Performance Partnership Grants program. Each state will negotiate, as a part of its contract with DHHS, an action plan specifying performance objectives achievable in a three to five year span. These objectives will be a combination of measures of health outcome, process, and capacity.

- The state Department of Health may provide technical assistance and consultation to tribes who want to strengthen organizational capacity, performance measures, and practice guidelines as a crucial step in improving the health status of Indian people.

Survey of tribes

The 1994 PHIP acknowledged the sovereign government authority of tribes, noted the special health needs of tribal communities, and offered an invitation for tribal authorities to join in the state-wide effort to build public health capacity. As part of this effort, the Department of Health funded a grant to the American Indian Health Commission to survey the capacity of individual tribes to perform the core functions of public health. For the tribal survey, the 39 indicators of the original survey instrument were only slightly modified to reflect the organizational differences between the local health jurisdictions and tribes. The tribal survey included two additional questions for each of the 39 indicators: 1) the level of importance assigned by the tribal health authority to the specific indicator and 2) for those indicators scored as at least minimally met, the providers responsible for meeting the performance indicator.

The survey was sent to all tribes in July 1996. Nineteen of the 26 tribes (73%) returned the survey. The responding tribes represent over 88% of the Indian Health Service (IHS) "active users" who rely on tribal or IHS health programs.

Local health jurisdiction and tribal survey findings are remarkably similar, particularly for the core functions of Assessment, Policy Development and Administration. Local health jurisdictions rated themselves somewhat higher than tribes for their current capacity to provide the core function of Prevention and lower for Access and Quality. Tribal respondents rate all core functions as being highly important to the health of their communities. Almost two-thirds of the capacity to perform the core functions is provided exclusively by tribal governments. State and local health jurisdictions contribute less than five percent of capacity.

Performance-based contracting

Performance contracting is another evolving effort that supports information-based decision-making, collaboration, and accountability. The long term goal is to more closely link priorities identified through community assessments to the funding and contract processes. Ultimately, contract "deliverables" will be tied to improved health status and enhanced organizational capacity. To determine ways of balancing local priority setting with requisite accountability, the Department of Health has begun an analysis of constraints imposed by federal programs and state requirements. Also underway is a comprehensive review to determine how contract work methods can be expressed in terms of broader functions that cut across categorical activities.

Quality improvement

Within the core function of access and quality, local health jurisdictions have responsibilities that are substantively different from those of the state Department of Health. Some local health jurisdiction responsibilities focus on health conditions: removing barriers to access for health care services, assuring that prevention activities and interventions are carried out for communicable diseases, and other locally identified health priorities. Others focus on community resources, assuring the competence of people who are not credentialed through a state process but whose work can have an impact on the public's health. Food handling licensing, restaurant inspection, and water quality monitoring are a few examples of these responsibilities. Throughout this report are discussions of how local health jurisdictions have carried out these responsibilities.

The state Department of Health's responsibilities for assuring access and quality are quite different in nature as well as scope. Most require close working relationships with both public and private entities. The department, for example, collaborates with 23 professional governing bodies to develop and enforce standards for 43 health professions. It works in partnership with the health services and facilities it licenses to assure consistent standards of care. It collaborates with the regional and local Emergency Medical Services and Trauma Care Councils to build and maintain the statewide trauma system. There are programs in the department that determine the availability and distribution of both facilities and health care professionals, and work in concert with local communities to increase the quantity and quality of health care resources in underserved areas. Upon request, the department advises the Legislature on the need to regulate or deregulate health professions and certain health services and facilities.

In addition to the above responsibilities, the department is committed to helping health organizations and providers improve the quality of their services. Since 1995 the department has had a voluntary quality improvement program that provides written materials and technical assistance to health carriers, medical groups, and community health organizations as they develop their own quality improvement programs. Two years ago the Legislature gave the department responsibility to collaborate with the Health Care Policy Board, other state agencies (through formation of the Interagency Quality Committee), and private organizations to develop quality assurance and improvement programs that could be used by all public and private health plans, providers, and facilities.

The department also has primary responsibility for leading the development of data standards that can be used by health care consumers, purchasers, providers, and state government. The health indicators identified in *The Health of Washington State* and the health priorities identified in the community health assessments will contribute to the identification and definition of population based health data standards.

Emergency Medical Services/ Trauma Care System

Since 1990 the Department of Health has collaborated with regional Emergency Medical Services and Trauma Care Councils, made up of physicians, fire services, ambulance services, hospitals and local government, to develop and implement the Trauma Care Plan. The plan addresses the need for a fast and coordinated response to life-threatening injuries whether the result of a motor vehicle crash in Friday afternoon traffic on I-5 or a weekend rock-climbing fall in the Cascades.

Washington's statewide trauma care system consists of 77 hospitals and clinics and the resources required for rapid transport to an appropriate facility. The providers range from Harborview Medical Center in Seattle to small rural clinics or hospitals. Medic 1 units, ambulance services and other first responders assess the patient's condition and transport directly or call for an air transport service to take the patient to the nearest trauma facility that can best treat the patient's injuries.

Gaps still remain in achieving some of the goals of the plan. Across the state there are communities which need to provide higher levels of trauma service to be consistent with the plan. Reimbursement for direct care of severely injured patients remains an unresolved concern for providers. The ability of the system to perform as expected is dependent on continued collaboration, voluntary provider commitment, community support and adequate reimbursement for care.

Temporary worker housing

The state Department of Health's role in temporary worker housing is a case study in public health leadership.

Operating in a complex regulatory environment with more responsibility than authority, the department is working with several other state agencies, local health jurisdictions, fruit growers and workers, the federal Occupational Health and Safety Administration, and the legislature to resolve persistent public health problems.

An acute housing shortage forces many migrant farm workers in Washington to camp in areas with no potable water or sanitation facilities. Federal regulations have had the unintended effect of discouraging the development of on-farm housing by requiring a shelter that many growers consider inefficient and overly expensive. Advocates for farm workers argue that strong enforcement of the existing standards would lead to improved housing conditions.

In a contentious climate, the department is making a distinction between public health policy and social policy on housing, and is using an epidemiological review of current standards, together with field experience gathered through pilot projects, to develop a base of accurate information for amending the standards.

Working with its many partners, the department is determined to maximize the protection of the public's health by applying standards that are protective as well as efficient and affordable, and by enforcing the standards equitably.

The department has also collaborated with university researchers and several private clinics to test the feasibility of using specific clinical outcome measures both to improve care and meet reporting requirements for health plans and health care purchasers. The pilot program has been very successful and more clinics are volunteering to use these outcome measures.

The department's involvement in developing data standards and uniform quality assurance and improvement programs is addressed in a separate report to the Legislature submitted by the department, the Health Care Policy Board, and the Interagency Quality Committee in December 1996.

The PHIP Steering Committee recommends that the state's and local health jurisdictions' roles in assuring the quality of health services should be studied and addressed in the next two years. This is essential given the changing health care system and increased competition in the health care market.

Regulatory reform

In 1995, the Legislature enacted substantial reforms to the way all state agencies develop, adopt, and enforce regulations. Because regulatory reform represents a way of doing business that complements other Department of Health priorities and the PHIP operating principles, the department has attempted to implement both the spirit and the intent of the 1995 legislation. Regulatory reform is consistent with the PHIP in that it emphasizes policy and standards based on solid, scientific data; solutions to problems crafted with broad community participation and input; and performance, outcome, and accountability.

Regulation remains an important tool to fulfill the core public health functions. For example, standards for drinking water quality, commercial shellfish harvest areas, and use of x-ray equipment are aimed at preventing health problems before they occur. Licensing and regulation of health care professionals, hospitals, pharmacies, and laboratories helps assure the quality and safety of services provided to the public.

The Department of Health operates within a regulatory framework that includes federal, state, and local governments, multiple rule-making authorities, and a wide array of constituents. In addition to the Secretary of Health, the state Board of Health and several appointed boards and commissions for various health care professionals have rule-making authority for Department-administered programs. The diversity of public health means that department regulations have an impact on a wide array of constituents, including home builders, physicians, hospitals, restaurants, public utilities, oyster growers, ambulance services, grocery stores, and pharmacies.

All Department of Health programs are working to improve the quality of new rules through a variety of means. These include more rigorous analysis and scrutiny of necessity and impact, earlier work with broader groups of stakeholders, clearer communication, and more stringent internal review. To assess whether a problem requires a rule, objectives

must be clearly stated, the economic impact and impact on public health must be rigorously analyzed, and non-regulatory options must be evaluated. DOH programs are reviewing existing rules to assess their impact on public health protection, economic impact, and continued necessity.

The Department of Health has also increased its focus on technical assistance, whether the recipient is a regulated entity, a local health department, a grant recipient, or a community contractor. Technical assistance for regulated entities focuses on voluntary compliance with standards and required procedures. The goal is to make formal enforcement action unnecessary. This aspect of regulatory reform dovetails with some of the quality assurance and quality improvement initiatives the department is working on with such entities as hospitals, retail food businesses, home care agencies, laboratories, and water systems.

This chapter has presented a sampling of actions underway to strengthen the public health system. The next chapter focuses on recommendations from the PHIP Steering Committee to build on these efforts.

Chapter 3

Recommendations

As described throughout this report, the PHIP is an ongoing effort to build and sustain a responsive public health infrastructure that protects and improves the health of people in Washington. The commitment to the PHIP can ensure that Washington has a public health system that reduces risks and dangers to people's health, responds to emergencies when they occur, and, at the same time, identifies emerging diseases and other emerging health threats. Ongoing implementation of the PHIP will yield these results.

This chapter contains the PHIP Steering Committee's recommendations, covering critical actions and next steps that need to occur as PHIP implementation continues. All recommendations will be reported on in the next biennial PHIP, due to the Legislature in December 1998. The recommendations are not in priority order.

Information-based decision-making

1. Develop health indicators and objectives.

Recommendation: The Department of Health should convene a work-group, involving technical experts and decision-makers, to determine: 1) a core set of health indicators; 2) a broader set of selected indicators for a statewide assessment document; and 3) state quantitative health objectives consistent with existing state and federal law. This group should include state agency representatives, state Board of Health, Health Care Policy Board, public and private providers, advocacy groups, health care purchasers, tribal representatives, community members, academics, as well as state and local public health officials. Determination of indicators should take into consideration previous work at the local, state, and national levels.

Rationale: Better informed policy decisions to improve health can be made with accurate and timely information. This information should cover health status, risk and protective factors that affect health, health care access, effective interventions that influence health, as well as identification of low quality, incomplete, or missing information that would be useful if available.

The health assessment efforts of the past two years have included the development the *Health of Washington State* and local community-level assessments for every local health jurisdictions across the state. In addition, health plans and health-related organizations are also engaging in health assessment activities to inform their policy development and

program management needs. Establishing a core set of health indicators, designating a broader set of selected indicators for a statewide assessment document, and establishing state quantitative health objectives would better coordinate and focus these varied assessment activities.

A core set of indicators would become the minimum data set for all assessment documents, allowing for direct comparability among these varied assessment processes. All health assessments would then include those indicators, plus others of particular relevance to a given local area. The broader set of selected indicators would be used for *The Health of Washington State*. Quantitative state health objectives should be developed and used to measure progress and evaluate program performance.

2. Coordinate the *State Public Health Report* and *The Health of Washington State*.

Recommendation: The Department of Health should convene a workgroup to identify how to link the discussion of health indicators and development of quantitative state health objectives in *The Health of Washington State* with the setting of state health goals in the Board of Health's *State Public Health Report*. The workgroup should include representatives from the state Board of Health, the Public Health Improvement Plan Steering Committee, the Legislature, the Department of Health, and local health jurisdictions.

Rationale: There has been overlapping work done in the past several years in producing the Board of Health's *State Public Health Report* and the Department of Health report entitled *The Health of Washington State*. The former is a legislatively-mandated report setting Washington's priority health goals to be used by state agencies. The latter is an objective assessment document intended to provide information for health policy decisions. Both are to be produced biennially.

The *State Public Health Report* contains the broadest statewide health goals, which should be determined partly through consideration of the health assessment information in *The Health of Washington State* and through public forums. There is an ongoing need for coordination in the development of these two documents, so their timing and content support and reinforce each other. Specifically, there is a need to ensure that the topics covered in depth in *The Health of Washington State* are both broad enough and detailed enough to provide the necessary information for setting statewide health goals in the *State Public Health Report*, which focuses on health-related activities of state agencies with responsibilities to protect the public's health.

Collaboration

3. Fund public health partnerships for the 1997-99 biennium.

Recommendation: A portion of the 1997-99 Local Capacity Development Funds should be designated for partnerships that enhance public health capacity. These partnerships should build and sustain core function capacity. Department of Health criteria for distributing partnership funding should emphasize development of all core functions.

Rationale: During the 1995-97 biennium the Department of Health funded twenty public health partnerships projects, with \$1.1 million set-aside from the Local Capacity Development Funds (LCDF). The projects emphasized the building of assessment capacity through collaborative models involving multiple local health jurisdictions and building collaboration between local health jurisdictions and Tribal governments. Although this is a new strategy and the full impact of public health partnerships as a capacity building strategy is not yet evaluated, partnership initiatives have produced specific plans for collaborative approaches to regional capacity development that increase the efficient use of public health resources. The formation of public health partnerships should continue in the next biennium by designating a portion of the LCDF for that purpose.

4. Analyze American Indian Health Commission proposed definition of tribal health jurisdiction.

Recommendation: The Department of Health and the American Indian Health Commission should analyze and study the impact and implications of adopting the commission's proposed definition of "tribal health jurisdiction" to include the following points:

- Tribal health jurisdiction authority and responsibility
- Changes to relevant RCW and WAC
- Current public health capacity of tribes
- Options for financing tribal public health capacity (including an inventory of current funding and the impact that state Local Capacity Development Funds have had on Indian people on and off reservation)
- Federal obligations for the public health of American Indians
- Collaborative models for improving/expanding the tribes' capacity within the public health system of Washington

Rationale: The 1994 PHIP recommends that state and local health jurisdictions recognize the autonomy of tribal governments and their independent authority for carrying out the core public health functions. The 1994 PHIP further recommends that the Department of Health take

a lead role in promoting the collaboration between tribes and local health jurisdictions, including agreement for supporting development of capacity functions and responses to public health emergencies based on a framework of government-to-government cooperation. The current statutory definition of Washington's public health system does not include tribes and their lands, consequently not acknowledging tribal governments as an integral part of the public health system and leaving a gap in the statewide system. In response to these issues, the American Indian Health Commission has proposed the following definition of a tribal health jurisdiction: "A 'Tribal Health Jurisdiction' means the sovereign authority and power of a Tribe to perform public health services within the territories and the lands of the Tribe, and for all eligible tribal members regardless of where they reside; and shall include the authority to regulate all individuals within the Tribe's territories when the exercise of such authority is necessary to protect the health and welfare of tribal members or the Tribe's interest in maintaining public health."

"Tribal health jurisdiction" should be defined as an initial step so that the Department of Health and the American Indian Health Commission can analyze how tribes can be recognized as part of the public health system within Washington state. The goal is to define a "seamless" system of public health services for all of the state and to have a consistent definition of tribal health jurisdiction that can be used in future documents and to assist in amending the applicable RCWs and WACs.

5. Convene a statewide dialogue to share information about collaborations among local public health, managed care plans and providers, and communities.

Recommendation: Building on the diverse experiences in communities across the state, the Department of Health and the Washington State Association of Local Public Health Officials should organize statewide meetings to share information and initiate joint planning as appropriate about partnerships among local public health jurisdictions, their communities, and managed care plans and providers. These meetings should include other partners such as the Department of Social and Health Services, Health Care Policy Board, Health Care Authority, Office of the Insurance Commissioner, American Indian Health Commission, and health plan and provider representatives. Topics should include formalizing agreements between managed care plans and public health, developing "best practices" information sharing and ongoing technical assistance, and developing new staff service delivery models.

Rationale: The Clinical Services Technical Assistance Project concluded that the dialogue and information-sharing fostered by the project should be sustained. Communities have much to learn from each other about health improvement in a managed care environment. Statewide meetings would provide the state's public health communities and their partners the forum for regular conversations, technical assistance, and

information-sharing on topics of interest and importance in the broad area of service provision. This would help improve access to care and coordinate efforts to improve and protect health.

Accountability

6. Use financing principles to guide public health system financing policy.

Recommendation: The “Public Health Financing Principles” (Appendix E) should be used by state and local governments to guide the development of state and local government financing policy.

Rationale: The financing of public health is a complex mix of federal, state and local government contributions, along with service and permit fees. Public health system financing has developed incrementally without established principles to guide policy. Currently, the funding sources and level of support for similar activities widely varies between local health jurisdictions. New state funds, designated to be flexible in building local health jurisdiction capacity, have been added since 1993 on top of a financing base which has lacked a consistent approach for system-wide development. In order to make the best use of current and future resources to strength public health protection and promotion, a framework of principles should be used to guide long term state and local policy.

7. Maintain a local funding base as state funding increases.

Recommendation: A county’s current funding of the local health jurisdiction shall be at least equal to the 1995 county contribution to the local health jurisdiction, subject to the review of the Secretary of Health, in order for a local health jurisdiction to receive its full share of state Local Capacity Development Funds for the 1997-99 biennium. The adequacy and appropriateness of that financing base should be studied and reported on in the 1998 PHIP.

Rationale: RCW 43.70.58 and WAC 246-05-030 both address the non-supplantation of state funds for local health jurisdictions. The ability to audit non-supplantation has been problematic due to the lack of a clearly defined county base of support. This recommendation is consistent with the financing principle which states, “additional state funding for local health jurisdictions shall not replace local government funding”.

8. Provide additional state funding for public health system development.

Recommendation: The Department of Health in its 1997-99 budget should request additional state funding to enable: 1) continued development of public health system capacity at the state and local level, and 2) local health jurisdictions to address public health issues identified through their community assessment process.

Rationale: The 1994 PHIP identified that public health activities are significantly underfunded to address health status of communities. A six year financing plan was proposed to build a strong public health system capable of carrying out the core functions. The Legislature has appropriated new funding in the past two biennia for development of state and local health jurisdiction core function capacity. Other system development has been achieved by reallocating existing resources and through re-deployment of personnel.

Additional state funding of the public health system in the 1997-99 biennium would continue the incremental progress toward full operating capacity and maintain the direction set in the 1994 PHIP for public health to play a significant role in improving overall health status.

9. Explore flexibility in federal funding.

Recommendation: The state should continue exploring federal funding flexibility in order to maximize the use of federal funds to build necessary core function capacity in the public health system.

Rationale: Over a quarter of the funding for local health jurisdictions comes from the federal government. Much of that funding is categorical to a specific program and comes through the Department of Health for distribution to local health jurisdictions, Indian tribes, and community organizations. The "Use of Federal Public Health Funds in Washington State" report indicated the potential for the department to assertively influence the grant process, through negotiations with the federal government, to allow a closer fit with state and local priorities. Federal public health funding could play an increased role in building core function capacity for both state and local health jurisdictions.

10. Develop new or revised regulations for local health jurisdictions.

Recommendation: The Department of Health should facilitate a workgroup to develop Washington Administrative Code (WAC) regulations to guide the performance of local health jurisdictions that are inclusive of the PHIP core functions.

Rationale: The public health system should have implementation rules which match the current and future direction of system development. The guidelines for local health jurisdiction responsibilities and functions

should be consistent with the core function framework and the 1995 Public Health Improvement Act. The current local public health guidelines (WAC 246-05-020) were last revised in 1982. Local health jurisdictions have identified the need for guidelines regarding local government support of activities such as health assessment and community mobilization. The Department of Health must work closely with the state Board of Health and other interested parties in the creation of any new rules.

11. Examine local health jurisdiction role in clinical personal health services.

Recommendation: Local health jurisdictions should engage in a systematic decision making process with community stakeholders prior to any change in their role or the level of provision of clinical services. The Critical Questions Checklist, developed as a product of the Clinical Services Technical Assistance Project, provides local health jurisdictions with a standard method to approach such decision making.

Rationale: The Clinical Personal Health Services Technical Assistance Project found that close collaboration between local health jurisdictions and their community partners is essential to assure access to clinical personal health services in a changing health environment. The project team and steering committee of the Technical Assistance Project developed a self-administered checklist of critical questions that local health jurisdictions should use with their communities in determining their preferred future regarding clinical personal health services.

12. Evaluate local decisions related to clinical services delivery.

Recommendation: The state, local health jurisdictions, and community leaders should jointly develop and carry out evaluations to determine the access to clinical personal health services, and to assess the degree to which health outcomes have changed through new partnerships between public health and community providers.

Rationale: The experience of the Clinical Personal Health Services Technical Assistance Project site visits indicates that local communities should evaluate whether or not the access strategies they have in place do, in fact, maintain or improve community health status. Since decisions about provision of clinical personal health services are best made in collaboration, the evaluation should also include community partners.

13. Clarify the state's role in assuring access to clinical services.

Recommendation: The 1998 PHIP should address the state's role in assuring access to clinical health services given the changing health system and health care market.

Rationale: The transformation of the health system, largely driven by market forces, raises questions about the ability of communities to meet the clinical personal health needs of residents. An analysis should be completed for the 1998 PHIP that would both provide updated information on the various programs in place to assure access to clinical personal health services and their capacity to meet this goal, the monitoring systems that must be in place to assess the capacity of the system and its ability to maintain and/or improve the health status of the community, and the relationship of these activities to public health's mission and its ability to provide necessary clinical personal health services.

14. Clarify state and local roles in assuring the quality of health services.

Recommendation: The 1998 PHIP should address the state's and local health jurisdictions' roles in assuring the quality of health services given the changing health care system and the increased competition in the health care market.

Rationale: Current state law directs the Department of Health to study the feasibility of a uniform quality assurance and improvement program. The scope of the directive moves the discussion of quality assurance into the area of accountability for system performance, and requires DOH and its community partners to address fundamental questions regarding the definition of quality, the relationship of quality to other characteristics of the health care system, public health's role in improving quality, and the ability of DOH and others to oversee quality under its existing statutory authority and responsibility.

15. Use the 1996 performance measure survey results.

Recommendations:

1. The state Department of Health, local health jurisdictions, and tribes should use survey information to describe progress made in building public health capacity, and to describe the current capacity needs of the system in support of a request for additional funding.
2. The state Department of Health and local health jurisdictions should use survey information to provide accountability and policy direction for contractual arrangements between the Department of Health and local health jurisdictions.
3. Survey information should be made available in an aggregated format to the Department of Health, local health jurisdictions, tribes,

the Northwest Portland Area Indian Health Board, the Legislature and other interested parties for use in developing health policy.

4. Local health jurisdictions and tribes should periodically reassess their core function performance in order to monitor progress, identify effective models, and guide the use of resources and technical assistance.

Rationale: Based on recommendations in the 1994 PHIP and legislation passed in 1995, a survey instrument has been developed which measures both local health jurisdictions' organizational capacity and their ability to carry out the core functions. This survey instrument has also been slightly modified to measure the capacity of tribes to perform core functions. Continued use of this instrument is essential in order to track progress in building the capacity needed to carry out the core functions and evaluate public health system effectiveness in addressing priority health issues. Information from this survey can inform both local, tribal, and state level decisions regarding best use of resources.

16. Continue to develop performance measures for the core functions.

Recommendations: In order to assure continued usefulness of the core functions performance matrix, the state Department of Health and local health jurisdictions should take several steps:

1. Undertake the development of core function performance indicators for the Department of Health following the procedural framework established for local public health jurisdictions.
2. Improve the reliability and validity for individual performance indicators.
3. Develop and carry out a procedure for community validation of local health jurisdiction assessment results.
4. Develop individual performance standards and indicators for the core function "Access and Quality".
5. For the purposes of quality improvement, develop best practices guidelines.

Rationale: The survey results, benchmarks and comments reported by local health jurisdictions in the July 1996 core function assessment will be used to improve the local survey process as well as individual performance indicators. The intent will be to improve the comparability of results over time and among the entities of the state's public health system, to involve the community in future assessments of public health and to expand core function measurement to the state level.

The next step is to develop a detailed work plan in early 1997 specifying how these recommendations will be carried out over the next two years.

Chapter 4

Future challenges

Protecting and improving the public's health requires public health agencies all across the state that are strong, flexible, well-prepared, and responsive. This depends heavily on good relationships — especially trust — among public health officials, medical care providers, community organizations, business, elected officials, and other community members. It takes time, effort, and resources to build and maintain these relationships.

Local health jurisdictions need funding that is flexible enough to allow them to adjust to the unique strengths and weaknesses of their particular communities. The state Department of Health also needs funding that allows it to adjust to changing conditions across the state.

A public health department is an agent of the community and its formal and informal leaders. If Washingtonians want a public health system that protects them from health threats, promotes healthy behaviors and communities, and mobilizes the strengths of communities, they must invest sufficient resources in that system.

The 1994 PHIP estimated that the public health system would need about \$104 million additional dollars annually by 2001 to fully carry out the core functions. In addition to new state funds appropriated in the last two biennia, a substantial amount of new funds are still needed, and new funds should be added incrementally to sustain growth and momentum.

For several reasons, the estimated need of \$104 million in additional funding by 2001 should be reanalyzed over the next two years. First, the assumption that the state would have implemented comprehensive health reform by 1999 no longer applies. Second, the funds received in the first two years of implementation were less than anticipated, so it would probably take longer to achieve the original total estimated increase. Third, the estimate did not account for efficiencies resulting from shared and reallocated resources. Fourth, the public health system now has additional experience and tools that will help in making a more precise estimate. The funding target should be evaluated in the next two years in light of the above changes.

The *Public Health Improvement Plan* is an ongoing incremental effort to protect and improve the public's health by building and maintaining a responsive public health system. The first few years of implementation have been successful in increasing core function capacity. Though the estimate of necessary resources may change, the goal of improved health through an integrated system of both population-based and personal health services has not changed. The commitment to developing necessary capacity to perform the core functions, as detailed in the "Core Function Capacity Standards" (Appendix G) has also remained constant.

The 1995 Public Health Improvement Act directs the Department of Health to work with its partners to develop key health outcomes and to measure the degree to which public health agencies have the capacity to

Flexible funding needed

Categorical or targeted funding is clearly having an effect on the ability of local health jurisdictions to fulfill the broad scope of their public health responsibilities. For example, in certain areas environmental health related programs are supported 100% through the collection of fee revenue. In accordance with state law, a fee cannot be established to generate revenues greater than 100% of the cost of performing the service for which the fee is created. Therefore, as an example, when an on-site sewage permitting program is established based solely upon fee revenue, those fees are collected to cover the cost of project specific site evaluations, system designs and installations, and final construction inspection activities. Fees cannot cover the broader, population-based elements of an on-site sewage program such as measuring the cumulative impact of on-site sewage disposal on regional ground water or surface water resources, or evaluating the operating status of existing system. In the absence of these activities there may be a lack of information for the long term management of water resources critical to the protection of public health. Given the rising public concern for safe and protected drinking water supplies, comprehensive information is critical for decision makers, including consumers, to make informed decisions about appropriate, long-term public health protection measures.

improve the public's health. The act also gives the department the responsibility to distribute funds to improve system capacity and enter into performance based contracts with local health jurisdictions. These contracts must identify improvements in both capacity and health outcomes.

The public health system and its partners have worked together over the past two years to begin meeting these requirements. Improving public health is an incremental, multi-year process. As issues are resolved, new ones emerge. For example, completing *The Health of Washington State* and many community health assessments has demonstrated the need for common health indicators and quantitative health objectives. Developing an organizational capacity measurement tool helped distinguish between concepts of "capacity" and "core functions" and provided a useful internal management tool, but it also showed the need for another tool that a local health jurisdiction's community partners can use to measure the effects of successful core function performance. Information from both of these processes must be used in the performance-based contracts between the department and local health jurisdictions.

It is essential that the public health system remain flexible and ready to respond to future challenges. Based on what is known today about the external environment, the PHIP Steering Committee has identified the following areas for the next two years of work. The 1998 PHIP will report on progress in these areas.

Information-based decision-making issues:

- Agree on a core set of health indicators for community and state health assessments.
- Revise state quantitative health objectives.
- Assure ongoing availability of comprehensive health assessment information (including a biennial *Health of Washington State* and local community health assessments).

Collaboration issues:

- Assure ongoing collaborative efforts to improve health in communities and statewide.
- Assist tribes in increasing tribal public health capacity.

Accountability issues:

- Continue to identify progress towards achieving improved health outcomes.
- Identify ways to assure core function capacity in smaller counties.
- Identify additional ways to maximize the use of existing and new resources.

- Develop “best public health practices” for state and local health jurisdictions, evaluation of program effectiveness at the state and local levels (including evaluation of interventions).
- Continue development and implementation of performance based contracts.
- Continue work towards maintenance of state and county base funding levels.
- Revise the Access and Quality Core Function to divide it into two distinct core functions.
- Continue efforts to review the state and local responsibilities to assure access to care as well as other public health services at the state and local levels.
- Develop more specific strategies to continue efforts to review the state and local responsibilities to assure quality of health services.

There has been important progress to date, and the effort to improve public health has substantial momentum, but there are still deficits in the system. Initial health assessments must be completed in all local jurisdictions and carried out on a sustained basis throughout the state. Community partners must be involved in decisions about priorities, health objectives, and policy implementation. Accountability must be improved by linking the use of resources with the goals of the state and local health jurisdictions. There is a need for more understanding of the effectiveness of population-based interventions. The role of state and local health jurisdictions in assuring access to and quality of health services needs clarification.

Many major external factors — some predictable, some not — influence what the public health system can accomplish in the future. Demographic changes, emerging diseases and health threats, and changes in the health care system can affect public health priorities and activities. New federal policies such as welfare reform affect what the public health system can and should do in the coming years. Federal budget cuts influence the resources available to fund public health activities, and state and local budget constraints create competition for scarce resources.

Meeting these challenges requires a collaborative effort. The PHIP Steering Committee, the Department of Health, local health jurisdictions, tribes, and the many other organizations and agencies that influence health must work together to make Washington’s communities healthier places to live, work, and play.

Appendix A. The public health system

In Washington State the public health governance structure consists of local health jurisdictions, local boards of health, the state Department of Health, and the state Board of Health.

Local Health Jurisdictions

The state of Washington, under Title 70 RCW, gives local government the primary responsibility for public health activities, which include authority for rule making and enforcement, program design, and assurance of access to public health services. Until recently, every city or town was required to form its own local health jurisdiction or be part of a county department or health district. The 1993 Health Services Act proposed several governance changes for local health jurisdictions.

Before the proposed governance changes from the 1993 Health Services Act became effective in July 1995, the Public Health Improvement Act (ESSB 5253) was passed into law. ESSB 5253 both delayed and repealed, as well as clarified, several of the measures passed in 1993. Relative to public health governance, ESSB 5253 made the following changes, all of which were in effect by January 1, 1996:

- Defined a local health jurisdiction as the local health agency, either county or multi-county, operated by local government, with oversight and direction from the local board of health, that provides public health services throughout a defined geographic area.
- Defined the public health system as the Department of Health, the state Board of Health, and local health jurisdictions.
- Clarified that counties have sole responsibility for local public health services.
- Defined local health board membership as the county executive and council members (for counties with home rule charter) or the county commissioners.
- Permitted the membership of elected city or town officials and non-elected persons on local boards of health as long as elected officials comprised a majority.
- Permitted the continuation of single county health districts.

Local Boards of Health

The local board of health is the governing body of a local health jurisdiction. The board has authority to appoint the local health officer and administrative officer, and to set policy. As described above, the composition of the board is elected county officials, either county commissioners or the county executive and council members, depending on the type of county government. Effective January 1, 1996, the elected county officials could add new members to the board, as long as the elected officials maintained majority representation. New members could be drawn from elected city or town officials within the boundaries of the jurisdiction as well as citizens of non-elected status.

Local boards of health transact their business in regularly scheduled public meetings. These meetings provide an opportunity for the community's involvement in making the decisions which determine the priority public health concerns and how they are addressed.

State Department of Health

The State Department of Health, the focal point for statewide public health system authority, was formed in 1989 from divisions in existing state government departments in order to give greater focus and attention to the issues which affect the public's health. The department works closely with several other state agencies and commissions which have important roles in developing and implementing health related actions and policies. In most cases the

department does not singularly affect a health outcome, such as heart disease or food borne outbreaks, but rather has a primary role, through its leadership, to influence the efforts of other agencies and organizations.

The Secretary of Health is appointed by the Governor and has broad powers under RCW 43.70.130 to investigate health threats, enforce public health laws, and generally supervise the statutory defined public health system for the purpose of establishing uniform monitoring and reporting of health threats. Although local health jurisdictions have the primary responsibility for preserving the public's health within their boundaries, the Secretary is empowered to intervene when the local jurisdiction either cannot or will not carry out necessary activities. The Secretary can also intervene in the case of a public health emergency, such as a major outbreak of communicable disease or a widespread environmental hazard, which has implications beyond the boundaries of the local health jurisdiction.

The authority of the Secretary was not changed by ESSB 5253, but the Department's responsibilities were expanded to include:

- Identifying the key health outcomes for the population and the capacity needed to improve health outcomes.
- Distributing state funds that, in conjunction with local revenues, will improve the capacity of the public health system.
- Developing criteria for measuring the degree to which capacity is being achieved.
- Evaluating, biennially, the effectiveness of the public health system, its capacity, and its influence on improving the public's health.

State Board of Health

The state Board of Health has a constitutional mandate to provide a forum for the development of public health policy in Washington State. The board has rule making authority to protect the public's health, improve health status of Washington residents, and "promote and assess the quality, cost, and accessibility of health care throughout the state," as stipulated in RCW 43.20.050 and RCW 43.70.050.

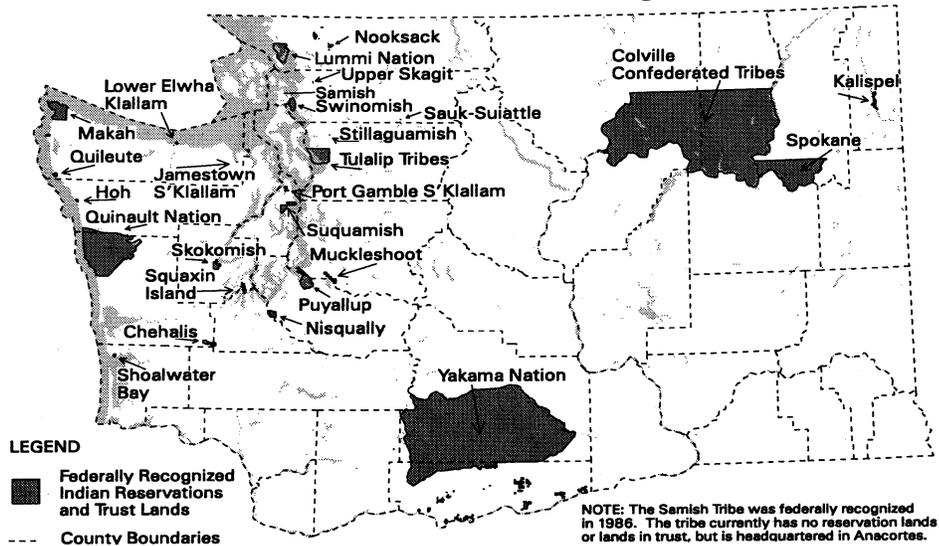
The state Board of Health is an independent citizen board composed of ten members appointed by the Governor broadly representative of consumers, persons experienced in matters of health and sanitation, elected officials, and local health officers. The board holds monthly public meetings throughout the state to gather citizen input on ways to improve the health of individuals and communities.

The 1994 PHIP identified the need to for clarification and coordination in the roles and responsibilities related to the biennial public health reports and rule making functions.

Local Health Jurisdictions of Washington State



American Indian Tribes in Washington State



Appendix B. Health system changes

The health system in Washington state is undergoing unprecedented changes. At the policy level, Washington has had dramatic shifts in health reform and insurance market regulations between 1993 and 1995. These changes—catalyzed by the actions of public and private sector purchasers, as well as by state policy initiatives—create a challenging environment for health providers, insurers, consumers, purchasers and for the state's public health system.

Washington's 1993 health system reform law, the Health Services Act (HSA), set in motion coordinated, phased processes and structures to achieve three goals: (1) control health care costs; (2) provide health insurance for all state residents; and (3) improve the health of Washington residents and communities. The Act defined a five-year plan to assure health insurance coverage for all state residents through creation of a comprehensive uniform benefits package, phased-in employer and individual mandates, and step-wise expansion of publicly subsidized insurance, including Medicaid and the Basic Health Plan. These policies were expected to reduce the uninsured population from an estimated 11 to 14 percent of state residents in 1993 to about two percent.¹ Coverage would be provided—and costs contained—through a marketplace of certified health plans overseen by the Health Services Commission, which would also set a cap on insurance premium increases. The Act also called for creating a statewide comprehensive information system to inform medical care and public health decision making in the reformed health system.

To meet the third goal, the Health Services Act mandated the biennial *Public Health Improvement Plan* as a blueprint for strengthening the state's public health system and improving health status. The relationship between reforming the health care system and public health improvement was described in the 1994 PHIP (page 4): “In the reformed health system envisioned for Washington, all state residents will be insured for a comprehensive set of benefits and will receive most of their personal and family care from practitioners through certified health plans. Local and state public health agencies will monitor health status and threats to health, helping communities set priorities and strategies for action, and assuring that strategies are carried out successfully.”

The 1995 Legislature repealed most provisions of the 1993 Act, including universal health insurance and the employer and individual mandates, the uniform benefits package, the premium cap, and replaced the Health Services Commission with the advisory Health Care Policy Board. These actions altered the nature of health system change from a publicly guided managed market place to one largely responding to market initiatives and decisions. The new laws left in place three original features of the Health Services Act:

- 1) Expansion of the Basic Health Plan.
- 2) Reform of some parts of the insurance market.
- 3) The commitment to public health improvement, with an infusion of \$9.75 million in new state funds to implement the PHIP.

Market Transformations

When the HSA was passed in 1993, managed care had already become an accepted feature of the state's health care delivery and financing system. Enrollment in the traditional model of managed care, health maintenance organizations (HMOs), had grown steadily since 1980, but remained at a moderate level of 18.9% of the state's population compared with other states such as Oregon (30.4%) and Minnesota (33.6%).² Likewise, other types of managed care, such as preferred provider organizations (PPOs), had been on a long-term growth path. This gradual expansion of managed care had been pushed by state purchasing decisions for state employees, Basic

¹ Washington Health Care Commission, Final Report, November 30, 1992.

² Marion Merrell Dow, Managed Care Digest, Update Edition, 1994.

Health Plan enrollees, and Medicaid clients (on a voluntary basis), and by various companies' employee benefit plans.

Along with managed care expansion, the hospital and health plan sectors had already experienced some consolidation by the start of the 1990s. Anticipation of a greater emphasis on managed care led to the development of at least three new health plans, and strategic relationships among former competitors took hold, in some cases resulting in statewide and multi-state networks.

The health care system of the mid-1990's reveals two kinds of shifts in market power. The first is a shift in power from service providers to purchasers. Some individual employers made bold moves to shift their workers to less costly health plans, responding to new financial incentives during 1996. Thirty-three percent of Boeing employees left that firm's traditional plan for four new managed care options, and 30,000 state employees and dependents shifted to HMOs. In addition, new and existing employer purchasing cooperatives began to flex their economic muscles. The state Medicaid program's statewide mandatory managed care initiative, Healthy Options,³ moved 300,000 Medicaid recipients into managed care by 1994. And the Basic Health Plan expanded its operations from a limited pilot project to a statewide program and now covers more than 100,000 people.

The second major shift in market power involves consumers. On one hand, the actions by large purchasers noted above place greater responsibility on some individuals to choose from among competing health plans. Economic incentives led people to make different choices that, in turn, may cause health plans to change their operations to become more attractive in the future. On the other hand, the public has expressed growing concern at market changes that they perceive as reducing people's choices. Some people have had to change long-standing relationships with their providers, while others have faced obstacles to obtain the types of care they think they need. The object of these complaints has been managed care, with a growing fear that these new large companies have gained too much power over health care. And fear seems to have led to a political backlash of laws designed to moderate this power: any willing provider laws, required coverage for post-natal hospital stays, and others.

Insurance market reforms promulgated as a result of the HSA also spurred changes in the market. In particular, the Insurance Commissioner's office set a three-month open enrollment period for individual policies in the fall of 1994. Able to obtain coverage without any pre-existing condition exclusions, people formerly covered through the state high risk pool and others signed up with insurers across the state. According to recent analyses,⁴ this development led to about 28,000 additional people with individual coverage, but also to significant increases in claims costs for the six largest carriers in the individual market. Subsequently, a number of insurers sought large rate increases (which have been challenged by the Insurance Commissioner) and one insurer decided to cease participation in the individual market.⁵ It is as yet unknown whether these events have affected the ability of uninsured people to obtain coverage.

³ Healthy Options is the managed care program for certain groups of Washington State Department of Social and Health Services (DSHS) clients who receive medical assistance. The Medical Assistance Administration (MAA) began statewide implementation of Healthy Options as a mandatory Medicaid program in 1993. In Healthy Options, each client enrolls in a managed care plan and has a primary care provider (PCP) in that plan who provides or arranges for all covered medical care 24 hours a day, seven days a week. Public health staff have been working together with MAA staff to monitor access and quality of care under Healthy Options. Local public health staff serve on many of the Healthy Options county oversight committees around the state. In addition, Department of Health staff have participated in many evaluation activities by serving on:

- The team which evaluated insurance carriers' contract proposals for Health Options;
 - TeaMonitor, which conducts site visits to the carriers for contract monitoring;
 - The steering committee which guides the external quality review process;
 - The Quality Control Oversight Committee, which has evaluated care for First Steps clients and families on SSI.
- In turn MAA staff provide quality of care data to county oversight committees, and participate on Department of Health advisory committees.

⁴ Health Care Policy Board, 1996.

⁵ Information derived from various issues of *Washington Health*, Health Policy Analysis Program, University of Washington School of Public Health and Community Medicine.

Implications for Public Health

The state policy shift and the turbulent health care market have changed the expected environment within which public health agencies attempt to strengthen their core function capacity, and to assure access to clinical personal health services. While the HSAs mandate that health plans provide services through managed care arrangements was repealed, the market place continues to emphasize this historical trend. HMO enrollment jumped to nearly 25% in 1994⁶ and, depending on the definition, two-thirds or more of the state's population is now covered through managed care.⁷ Even rural Washington has experienced this growth, with about 34% of rural residents covered by managed care products.⁸

Repeal of the uniform benefits package and the lack of federal health care reform mean that public health agencies will find it more difficult to assure that residents have access to needed services. Managed care benefits now vary widely and change often, so it is often hard to know who has adequate coverage for which services. Moreover, managed care expansion may not have dramatically reduced the proportion of the state's population that is uninsured; a 1996 estimate by the Health Care Policy Board still shows about 12% of state residents without coverage.⁹ This estimate suggests that, while the BHP has provided coverage to more lower income enrollees and insurance reforms led to more people covered by individual policies, this progress has been offset by other changes (e.g., shifts in jobs and employee benefits, changes in insurance affordability).

Market forces may allow synergies between the missions of public health and health care to develop in the areas of quality and health promotion. Private and public purchasers may continue to pressure insurers and providers toward greater efficiency and better outcomes, driving competition as intended by both 1993 and 1995 state legislative actions. Purchasers continue to work toward improved quality and outcomes through competition among health systems, as evidenced by the moves of health plans to gain certification by the National Committee for Quality Assurance and other entities. The 1995 legislative changes make it less clear with whom public health will enter into partnerships, how strong incentives will be for insurers and providers to cooperate for the purpose of improving health status, and to what extent collaborations will occur in all communities across the state.

Today, a major issue for many local public health jurisdictions is whether and how to move from providing certain direct clinical services as part of their efforts to concentrate on the needed capacity to protect the health of the entire community. This issue is not a simple one, because local public health departments and districts across the state vary widely in the extent to which they provide clinical personal health services. For example, the Seattle-King County Department of Public Health has provided primary care services for children since the mid-1960s, and today is a participating provider in some managed care plans. Most other jurisdictions, however, have provided only limited immunization, well-child, and sexually transmitted disease services, referring clients to community providers for other services. Such services are financed through various mechanisms, including state and local government contributions, fees from clients, and federal grants. Differences in the mix of revenue sources, the availability of other community resources, and local priorities have affected—and will affect in the future—community decisions about local health jurisdictions role in providing clinical services.

Without organized moves toward universal access and an adequate information system, local jurisdictions must continue to serve or facilitate provision of services for unsponsored or uninsured residents, with fewer tools to verify or ensure that such services are being provided by the private sector. This uncertainty may become even more problematic as a result of two recent developments:

⁶ Hoechst Marion Rousel (formerly Marion Merrell Dow), HMO-PPO Digest, 1995.

⁷ According to The 1995 Book of Lists, Puget Sound Business Journal, the 10 largest HMOs and 10 largest PPOs serve about 3.4 million people.

⁸ Rural Managed Care Inventory Final Report, prepared for the Washington State Department of Health by the University of Washington Health Policy Analysis Program, June 1996.

⁹ Health Care Policy Board, 1996.

(1) The 1996 enactment of federal welfare reform separates eligibility of low income families for cash assistance from Medicaid eligibility. The law also sets time limits for cash assistance, excludes certain children from SSI benefits, and restricts the types of immigrants who are eligible for medical and income assistance. No one knows how these changes will affect access to and quality of health care.

(2) The state legislature has required the Healthy Options program to move to selective contracting. Previously, the Medicaid program contracted with all health plans in an area that wanted to participate in Health Options. Under selective contracting, Medicaid will only contract with those health plans that meet certain goals, including low price. In some communities, this policy may require that people change health plans and perhaps, primary care providers. Again, it is not known with certainty the effect of this change on access and quality.

Local health jurisdictions also have less guidance now about how to address issues that could involve, or overlap with the activities of health care providers and insurers, including both health promotion and protection and the provision of clinical personal health services. However, the emphasis on outcomes and health status among managed care plans presents to public health jurisdictions an opportunity for potentially powerful collaborations to improve community health. Local health jurisdictions act as community catalysts, conveners, facilitators, and mobilizers to assure access to the necessary health care services.

Appendix C. Health in Washington State

The following is a summary of information in the DOH report *The Health of Washington State*. The summary was part of a news release the department issued on October 22, 1996, when the report was made available publicly.

Trends

The health of Washington's population is improving. Across a broad spectrum of major health indicators, trends since 1980 are positive more often than not, with declines in heart disease, motor vehicle deaths and infant mortality; improvements in access to prenatal care; and lower incidence of many infectious diseases.

National comparison

Washington is not the healthiest state, but it is healthier than average. There are a variety of possible explanations for this, including personal lifestyle choices, economic conditions, the public health system, the medical care system, demographics, and environmental conditions.

Variation by population group and locale

Despite generally positive health, significant challenges remain. One is the difference between the health of the total population compared to that of minority groups, some of which have worse health outcomes for many indicators. The causes of these differences are not well understood, but appear related to socioeconomic conditions. Some minority groups tend to have high poverty rates. Poorer health outcomes are more common among low-income people of all races. Health indicators may also vary significantly on a geographic basis.

Deaths

Washington's overall death rate is lower than the nation's. About 40,000 deaths occur each year. More than 80 percent are due to 10 leading causes. In 1994, these causes were heart disease, cancer, stroke, chronic obstructive pulmonary disease, unintentional injuries, flu and pneumonia, diabetes, suicide, HIV and liver disease.

Death rates have declined gradually but steadily since the mid-1930s as a result of improved public health and medical practices. For most major causes of death, including chronic illness and injury, rates are below national rates. Exceptions are chronic obstructive pulmonary disease and suicide.

Death rates for heart disease, stroke, and unintentional injuries have declined in recent years. The overall cancer death rate has not changed significantly, and the rate for chronic obstructive pulmonary disease has been increasing.

Females have significantly lower death rates than males, and their life expectancy is several years higher.

Maternal and child health

Rates of infant mortality and low birth weight are significantly lower than national rates. Infant mortality continues to decline, while low birthweight has not changed over time. The percent of pregnant women receiving prenatal care in the first trimester has increased since 1989, and is slightly higher than in the nation as a whole.

Pregnancy rates among 15 to 17 year olds have declined in recent years and are significantly lower than the national rate. About 32,000 births per year, an estimated 40 percent, result from unintended pregnancies — a lower percentage than the nation, but still a large number of births.

Infectious disease

Rates of most sexually transmitted diseases compare favorably with the nation and are declining. Tuberculosis trends and national comparisons look favorable, despite the fact that Washington is impacted greatly by cases among immigrants who got the disease in their countries of origin.

Immunization rates for school-age children are high. The ability to measure immunization rates among pre-school children has historically been poor. Those rates are generally lower than the rates for school-age children, but there are signs they are improving. A rough estimate is that at least 150,000 children under age six are not adequately immunized.

Rates of many infectious diseases are extremely variable from year to year. Hepatitis A and meningococcal disease are of particular concern and are being watched closely. Washington has relatively good surveillance and reporting systems, so rates may appear higher than the national rates because the reporting is more complete.

Behavioral risk and protective factors

Health is to a great extent determined by personal behavior. Surveys indicate that for most personal risk and protective factors, such as smoking, alcohol and drug use, or exercise, residents take better care of themselves than other Americans. However, more than 850,000 adults still smoke, and smoking among youth is increasing. And, while Washington has one of the highest rates of physical activity in the nation, almost half of all adults — more than 1,800,000 — are not as active as recommended.

Socioeconomic conditions

Poverty, unemployment, lack of education, and other indicators of low socioeconomic status are often associated with higher rates of health problems. Washington residents are fairly prosperous and well-educated. According to the 1990 census, 10.9% were below federal poverty level compared to 13.1% nationwide. Median household income was \$31,183, compared to \$30,056 for the nation.

The average annual unemployment rate from 1992 to 1994 was 7.1%, compared to 6.8% nationwide. During the 1980s, the overall unemployment was higher than the nation's, but in the 1990s rates have been similar.

According to the 1990 census, 16.2% of people age 25 or older did not have a high school diploma, compared to 24.8% nationwide.

Race and Ethnicity

In the 1990 census, most residents (88.5%) identified themselves as white. The largest minority racial group was Asian/Pacific Islanders (4.3% compared to 3% nationwide). The health status of Asian/Pacific Islanders appears to be better than that of the general population.

African Americans (3.1% compared to 12% nationwide) have higher rates of many health problems than members of other races. Problems in 1994 included infant mortality, low birth weight, sexually transmitted diseases, homicide, coronary heart disease, stroke, cancer and chronic lung disease.

American Indians and Alaska Natives (1.7% of Washington's population compared to less than 1% nationwide) also had higher rates of some problems than other racial groups in 1994, including tobacco use, breast cancer, head and spinal cord injuries, motor vehicle deaths, youth suicide, and lack of prenatal care.

The environment

Improvements in outdoor air quality, safe drinking water, cleanup of hazardous waste sites and food protection during the last 20 years have decreased some threats of illness and disease transmission. However, population growth is putting more stress on the environment.

There are significant sources of six nationally-regulated pollutants: particulate matter, carbon monoxide, nitrogen oxides, sulfur oxides, ozone, and lead.

There also are growing demands for safe and adequate water for drinking, recreation, fish and shellfish habitat, irrigation, and electric power generation. The quality and availability of water are at serious risk in areas where drinking water is taken from surface supplies, where there is heavy agricultural activity, or where there is salt water intrusion.

Three million people live in the Puget Sound area and use the sound as a waterway, food source, recreational area, and place of business. Virtually no area of Puget Sound is pristine and free from contamination. The worst chemical contamination shows up in the bottom sediments of urban bays. During the last 15 years, a substantial portion of Puget Sound's shellfish growing areas have been closed to harvest due to water pollution.

Health systems

In 1993, the ratio of health care practitioners to the population was better than that for the nation. There were about 172,000 practitioners.

There are a great variety of physical facilities and organizations in which practitioners work, but the concentration of more specialized facilities or services in large population centers makes access less convenient for rural residents.

The medical care system is undergoing unprecedented changes. The most critical trend is toward managed care, an integrated system of health insurance, financing, and service delivery.

About 88 percent of people have health insurance or other financial coverage. More than 50 percent have health insurance purchased through employers, while almost 27 percent have publicly funded coverage through Medicare, Medicaid, or some other government program.

Appendix D. Local Capacity Development Fund Projects

Building healthy communities

Throughout Washington State, local health officials and concerned community members are working together to determine what are the most important public health problems facing their communities. They are deciding what solutions will work best for them. They have initiated nearly 200 programs designed to improve the health of their communities and to strengthen the public health system at the local level.

Use of Local Capacity Development Funds January through December, 1996

Activity Type	Budget Amount	% of Total
Assessment (54 Initiatives)	\$2,557,940	30%
Prevention: (50% of Total)		
Environmental Health (35 Initiatives)	\$ 777,935	9%
Family & Individual (23 Initiatives)	\$ 933,415	11%
Health Education (2 Initiatives)	\$ 464,308	6%
Infectious Disease (20 Initiatives)	\$1,024,118	12%
Non-Infectious Disease (11 Initiatives)	\$ 451,479	5%
Violence & Injury (11 Initiatives)	\$ 580,968	7%
Administration/Policy Development (25 Initiatives)	\$ 998,506	12%
Quality & Access (8 Initiatives)	\$ 696,582	8%
1996 Total	\$8,485,251	100%

Strengthening local systems: Flexibility is key

The majority of funding for these community-based efforts was provided by the Legislature to help implement the *Public Health Improvement Plan*. These funds are flexible, designed to ensure that local communities have the resources they need to solve public health problems in a manner that fits their particular circumstances.

In 1993, the Legislature recognized the need for flexible resources to improve local public health systems by appropriating an initial \$10 million to begin local implementation of the *Public Health Improvement Plan*. In 1995 the Legislature reaffirmed its support by providing an additional \$4.75 million in flexible funds, allowing communities greater control in directing public health dollars toward local priorities. Most of these *Local Capacity Development Funds* are distributed to jurisdictions based on population size.

Providing public health resources with local flexibility is a significant departure from public health system funding trends. Over the past several years, the public health system had to rely on funding that is linked to specific "categorical" state or federal programs, on fees for licenses or permits, and on reimbursements for specific clinical

personal health services. These sources of funds support essential functions and provide targeted resources to address pervasive public health issues. However, the funds are very restricted in how they can be used, so they are not flexible at the local level. Some federal and state funds require local contributions of "matching funds" which further reduces flexibility for local jurisdictions. Over-reliance on restricted sources of funding can leave the community with little flexibility to meet local needs or to assure that basic public health systems are in place and maintained over time. With restricted funding, the focus is on program administration and cost reimbursement for highly specialized services. If too great a portion of a public health jurisdiction's financial resources are restricted in this way, the community is vulnerable during disease outbreaks or other public health crises because they have no immediate resources to respond to emergencies. Community-wide prevention strategies go undeveloped for lack of a specific funding source and little effort is expended to get the communities actively engaged in health issues.

By providing flexible resources directly to communities, the PHIP is assisting communities in strengthening, and in some cases restoring, the basic components of a public health system: population-based disease prevention and health promotion. Population-based interventions provide local public health jurisdictions with the ability to *prevent* outbreaks, such as making sure that all children are immunized by the appropriate age; to *respond* to an outbreak once it has occurred; and to *promote* healthy conditions within the community, such as making sure that the drinking water is safe. Although these population based activities rarely qualify for categorical funding, they are the promise of public health--the capacity to prevent illness through broad-based, community-wide activities.

Local Capacity Development Funds are changing the public health system in important ways. First, the amount of funding for basic community-level prevention and protection has increased. Second, communities have a source of public health funding that is flexible enough to direct toward local problems and local solutions. Before 1993 there were almost no flexible funds provided to local jurisdictions by the state or federal government. By 1996, the LCDF comprised 10% of the state and federal funding passed on to local health jurisdictions by the Department of Health.

Strengthening local evaluation and quality improvement

Flexibility in fund allocation does not have to lessen accountability or reduce evaluation. On the contrary, with Local Capacity Development Funds, although each initiative is developed locally, it is linked to the Year 2000 Health Objectives/Model Standards. These are nationally accepted standards for public health protection, prevention and promotion interventions. The objectives provide a framework for effective intervention strategies and provide standard ways of measuring success, while encouraging local innovation. Local public health jurisdictions identify both quantitative and qualitative measures prior to receiving their flexible funds, and submit regular progress reports throughout the biennium to the state Department of Health. The reports provide an accounting of the priorities selected by local jurisdictions and they also serve to inform others about successful work that may be implemented elsewhere.

The Department of Health publishes and distributes a catalog of all local initiatives pursued with Local Capacity Development Funds, and includes contact names and phone numbers in order to promote communication and collaboration among all local public health jurisdictions. This cross jurisdiction communication is a quick way to share innovations and to improve the systems by learning from one another's successes and challenges.

Local initiatives for public health improvement

During this biennium, each of Washington's 33 local public health jurisdiction used flexible funds to conduct their own community health assessment, gathering baseline data regarding the health status of their communities so that public health expenditures and efforts could be directed to the most urgent problems. They also implemented initiatives to address high priority public health needs that either required additional funds, or had no other funding sources. They used some funds to support collaboration efforts with other local stakeholders, working together to discover the most effective solutions to local public problems.

Following is a brief summary of nine areas in which local capacity funds are being used, with examples provided from among nearly 200 specific initiatives.

Community health assessment

The state Department of Health directed each local public health jurisdiction to carry out a community health needs assessment during this biennium. Thirty percent of the flexible funds went towards meeting this goal during 1996. By July, 1997, all 33 local health jurisdictions will have completed their initial community health assessments and will have published a community health status report. As a result, all counties within Washington state will have baseline health data with which to begin making informed decisions regarding expenditure of public health dollars in their communities.

- Thurston County Health & Social Services Department completed its community health assessment and distributed its health status report, the first comprehensive look at Thurston County which considered the health of its inhabitants and the health risks present in the environment. The document included environmental data, birth and prenatal statistics, infectious disease rates, injury morbidity and mortality rates, and maps, including growth areas, landfills and dumps, and zoning areas. A Thurston County Community Health Task Force reviewed the health data and identified 14 public health priorities and developed intervention strategies. This task force is made up of representatives from local health care, schools, business, churches, civic interests, labor, law enforcement, and environmental interest groups. Once the group identified the community's health priorities, it developed a variety of strategies for each health problem and then appointed responsibility for carrying out the strategies among task force representatives. In May 1996 the Thurston County Community Health Task Force released its *Strategies For a Healthy Future First Year Report*, outlining the actions taken, and by whom, for each of the fourteen priority problem areas identified.

Environmental health protection

Environmental health programs have been especially affected by funding trends that tie revenue to fees for licenses and permits, where revenues are limited to use for fee-supported services. Flexible funding has been essential to undertake broader goals for public health improvement and protection in environmental health.

Twenty-five local public health jurisdictions used flexible funds to support a total of 35 Environmental Health protection initiatives. Most of the investments were in food safety and water quality protection programs.

- Grays Harbor County Health Department worked with its planning department and Board of Health to develop a policy to ensure there is drinking water in sufficient quantity *before* subdivisions are approved. Funds also supported completing an inventory of all known public water supplies and increased sampling, technical assistance and education to preserve drinking water quality.
- Mason County Health Department conducted dye tests to identify failing on-site septic systems that were leaking into the bay in the Lower Hood Canal Clean Water District. Septic system failures threaten water quality, may expose people to disease, and can render shellfish inedible.
- Skagit County Health Department expanded its food safety program by adding educational programs based on the Hazard Analysis Critical Control Points system, increasing inspections, developing materials about foodborne illness and prevention for both the food service industry and the public, and establishing a rewards program for restaurants that maintain excellent safety standards.

Family & individual health promotion & disease prevention

Seventeen local public health jurisdictions used their flexible funds to enhance or develop initiatives that prevent health problems for individuals or among families in their communities. Examples of these initiatives included pregnancy prevention, teen advocacy programs, parenting and child care programs, and dental health.

- Whitman County Health Department provided dental screenings, education, and referrals to children who would not otherwise have been able to receive dental screenings due to socio-economic and geographical barriers.
- Tacoma-Pierce County Health Department worked with a local non-profit agency to address risks to teenagers including lifestyle choices, substance abuse and pregnancy. They developed a detailed database for referrals for services and supportive resources and began a peer mentoring program.

Infectious disease prevention

Fifteen local public health jurisdictions chose to direct their flexible funds towards preventing infectious diseases within their communities. Overwhelmingly, local public health jurisdictions used these funds to expand STD prevention and control programs; to develop immunization monitoring systems and improve immunization rates; and to support tuberculosis prevention and improve therapy efforts, in some cases, by providing directly observed treatment when necessary.

- Cowlitz County Health Department expanded their tuberculosis screenings to include high-risk populations. As a result, the department administered an additional 354 skin tests and identified 18 positive cases.
- Seattle-King County Department of Public Health added specialist staff time to provide screening for people at especially high risk for sexually transmitted disease, provided diagnosis, treatment and follow-up and developed a database to help assess where new risks are emerging.
- Southwest Washington Health District purchased medication for clients with tuberculosis who would be unable to purchase medication on their own, provided nutrition counseling, and tracked therapy completion rates. They also coordinated TB education programs for other providers and provided consultation to areas where there is a high risk of TB, including shelters, substance abuse treatment programs, and jails.

Non-infectious disease prevention

In its effort to prevent disease and promote health, public health has led the fight against many non-infectious diseases by addressing the major risk factors which contribute to these diseases. Risk factors that impact cancer, heart disease, diabetes, and osteoporosis include tobacco use and exposure, diet, and physical activity. Public health's population-based approach works well for prevention activities. In fact, prevention is public health's only role when it comes to non-infectious diseases.

Nine local public health jurisdictions directed flexible funds to enhance tobacco use prevention and cessation programs, especially programs aimed at preventing youth from ever beginning to use tobacco.

Violence and injury prevention

Ten local public health jurisdictions applied flexible funds toward violence and injury initiatives. These local initiatives include promoting bike helmet use; providing infant car seats to those in need; evaluating day care centers for injury or health hazards; educating day care workers how to protect the children; and teenage intervention to prevent gang involvement.

Quality and access

Six local public health jurisdictions used flexible funds to identify areas of poor access to medical and preventive services within their communities; to expand services to youth and multi-cultural populations; and to provide services that are not available within their communities, such as preventive dental services for uninsured children.

- Seattle-King County Department of Public Health used flexible funds to improve access and services for underserved populations within King County. The health department's community health referral program staff collaborated with community and private providers to find dentists for 311 children in desperate need of dental care.

Administration/policy development

Sixteen local public health jurisdictions used flexible funds to strengthen their capacity to carry out public health interventions. These local initiatives included developing information and data collection systems, and improving antiquated or non-existent internal management systems.

Public health partnerships

In two funding cycles, the Department of Health funded 20 partnership projects involving 25 local health jurisdictions, eight Indian tribes, and several other organizations. These projects involved a variety of activities and collaborative models. Partnerships projects are shown in tables on the next two pages.

PUBLIC HEALTH PARTNERSHIP (Projects starting 1/1/96)	Local Health Jurisdiction
<p>Bridge Assessment: A three-LHJ project to conduct community health assessments, including joint use of a demographer to serve the region by providing training and technical assistance for each county and performing special analyses.</p>	Bremerton-Kitsap Clallam Jefferson
<p>Jefferson County: A six-agency consortium that will provide community analyst staff to coordinate local health assessment work among the partners (Jefferson County Health & Human Services, Jefferson County Hospital District, Olympic Area Agency on Aging, Clallam-Jefferson Community Action Council, Community Counseling Center, Kah-Tai Care Center).</p>	Jefferson
<p>Northwest Public Health Partnership: A three-LHJ project to establish a regional epidemiology service to assist each partner with local health assessment activity, conduct investigations of public health issues, and implement a centrally-managed electronic network.</p>	Island San Juan Skagit
<p>Neighbors: A three-LHJ project to coordinate disease surveillance and response systems, relying on the epidemiologist staff of the larger LHJ to provide training and technical assistance to the smaller LHJs.</p>	Northeast Tri-County Spokane Lincoln
<p>Island: The hospital and LHJ will collaborate in carrying out a behavioral risk factor survey as a basis for development of intervention strategies to be used in the community.</p>	Island
<p>Southeast Washington Public Health Group: A four-LHJ consortium to strengthen and standardize administrative systems, including fiscal accounting systems, computerized BARS reporting, standardized policy and procedures, and increased health officer time.</p>	Columbia Asotin Garfield Whitman
<p>Southwest Washington: A two-county collaboration in which Southwest Washington Health District will provide technical assistance to Cowlitz County on the development of a community assessment and strategic action plan.</p>	Southwest Washington Cowlitz
<p>Whitman County Alliance: Provides staff support to a community-wide, multiple-agency Alliance currently involved in community health assessment including analysis of public health data, BRFS results and development of strategies in six health planning regions in the county.</p>	Whitman
<p>Asotin/ Garfield /Columbia: A three-LHJ consortium to carry out county-specific community health assessments using a single contractor to coordinate activities and guide the processes undertaken in each community.</p>	Asotin Garfield Columbia
<p>Thurston: A Behavioral Risk Factor Survey will be carried out with collaboration and financial participation by other community agencies.</p>	Thurston
<p>Community Assessment Partnership Agreement: A five-county consortium will establish centralized consultation for each LHJ's community assessment work in order to access epidemiologic expertise as well as provide coordination and technical assistance with each project.</p>	Mason, Lewis, Pacific, Grays Harbor, Wahkiakum

PUBLIC HEALTH PARTNERSHIP (Projects starting 7/1/96)	Local Health Jurisdiction/Tribe
<p>Clallam County Tribal -- LHJ Partnership: The Clallam County Department of Health and Human Services will provide organizational support and funding in a cooperative effort with four tribes to address common public health goals, methods for sharing technical resources and a framework for continued collaboration in public health.</p>	Clallam, Makah Tribe, Lower Elwa Klallam Tribe, Quileute Tribe, Jamestown S'Klallam Tribe
<p>Kittitas Community Assessment Partnership: A Behavioral Risk Factor Survey will be carried out under the direction of the Kittitas County Health Department in collaboration with Kittitas Valley Community Hospital, Kittitas County Public Health & Safety Network, and the Kittitas County Mental Health, Substance Abuse and Developmental Disability agency.</p>	Kittitas
<p>VISTA Dissemination Project: The Seattle-King County Department of Public Health will provide software, training and support to 20 local public health jurisdictions outside King County in the use of VISTA. This computer program will enhance each LHJs ability to carry out rapid, customized analyses of data needed to support community health assessment activity.</p>	Seattle-King & 20 other LHJs
<p>Snohomish Health District & Tulalip Tribes: The Tulalip Tribes and Snohomish Health District will partner in an effort to conduct health promotion and disease prevention activities in the Tribal community.</p>	Snohomish, Tulalip Tribes
<p>Washington State Drinking Water Data System: The Washington State Environmental Health Directors, with assistance from the Washington State Department of Health, will use partnership funds to support staff time and project coordination to develop a common data system for tracking and maintaining information about drinking water systems throughout the state.</p>	ALL LHJs
<p>Thurston County Public Health & Chehalis Tribe: Thurston County Public Health & Social Services Department and the Chehalis Tribe will combine skills and resources to enhance public health protection in water quality, food safety and wastewater disposal.</p>	Thurston , Chehalis Tribe
<p>Whatcom County Health Department & Lummi Nation: Whatcom County Health Department, the Lummi Nation and Group Health Cooperative will combine efforts to carry out a Behavioral Risk Factor Survey in face-to-face interviews among members of the Lummi Nation.</p>	Whatcom, Lummi Nation
<p>Central Washington GIS Data Partnership: This five-LHJ project will provide a regional Geographic Information System. It is expected to begin with environmental health data and later expand to include a broad range of health indicators and to include other LHJs.</p>	Kittitas, Adams, Grant, Chelan-Douglas, Okanogan
<p>Spokane Tribe & Northeast Tri-County Health District: The Spokane Tribe of Indians and the Northeast Tri-County Health District will develop information and a report on health status of enrolled Spokane members residing on the Spokane reservation in Stevens County.</p>	Northeast Tri-County, Spokane Tribe

Appendix E. Financing principles and fee principles

The Finance and Governance Technical Advisory Committee developed—and the PHIP Steering Committee approved—two sets of principles that can serve as guidelines for state and local government financing policy. The Public Health System Financing Principles are broad statements intended as a starting point for consideration of long-term state and local financing decisions. The Fee Principles for Local Health Jurisdictions are directed toward decisions about setting fees for public health activities. The two documents are intended to complement each other.

Financing Principles: The Public Health System Financing Principles are general statements that cover topics of public benefit, incentives for promoting system efficiency, stability of financing, and equity of opportunity for basic public health protections. They are based on three assumptions:

- 1) State and local government have a shared responsibility, along with the individual and community, in the protection and promotion of the public's health.
- 2) A well functioning public health system requires an adequate base of support from state and local government.
- 3) A fundamental level of capacity is needed throughout the state for carrying out the core public health functions.

To make the best use of the resources available for strengthening the system, these principles should become the framework for guiding public health financing policy. To best understand their impact in guiding policy decisions, the financing principles should be considered as an interactive package of components, rather than as separate, isolated rules.

The Financing Principles are as follows:

1. All public health activities have some degree of public benefit and vary along a continuum of benefit, from primarily benefiting individuals to primarily benefiting communities. In some cases, public health activities have a population-based benefit while being directed at an individual or family. The degree of benefit to the individual and the community, as well as whether the activity is conducive to fee collection, are two of the factors that should be considered in determining the financing of a public health activity. (For more information see the Fee Principles for Local Health Jurisdictions)
 - a) When an activity has primary benefit to an individual or an organization (e.g., food establishment permits, travel immunizations) or protects the public from individual choices (e.g., on-site sewage permits, food handler's certification) a greater share of the cost should be passed on, through a fee or permit, to the individual or organization.
 - b) When an activity has primary benefit to the community (e.g., communicable disease investigation, community health assessment) more of the cost should be publicly subsidized.
 - c) In the event that charging a fee jeopardizes community health status by creating a barrier for accessing the service (e.g., HIV counseling and testing, childhood immunization) or for compliance with a regulation (e.g., temporary food establishment permits, on-site repair permits), the local health jurisdiction should have an established policy for fee waiver, adjustment, or subsidy. There are circumstances where an individual can not pay, and a fee subsidy should be considered. This, in turn, may require public subsidy of the activity.
2. When a public health activity has benefits to the population beyond the boundaries of the public health jurisdiction (e.g. response to a public health emergency, groundwater monitoring, information networks), a

regional financing strategy (e.g., funds, staff, resources, mutual aid agreements) involving state, local, and tribal governments should be developed.

3. The recipients of state public health financing should be accountable through performance-based contracts for:
 - a) establishing the capacity to perform core public health functions.
 - b) contributing to the improvement of community health status by impacting health risk and protective factors.
4. The state should provide start-up financial incentives to initiate the formation of long-term partnerships between local health jurisdictions, tribal governments, community based organizations, and other organizations, which will increase regional capacity and improve the overall efficiency and effectiveness of the public health system. (See the Public Health Partnership Principles).
5. The state will intercede when a local health jurisdiction has not independently attained the capacity required to perform the core public health functions and has not entered into a partnership as a means to improve performance. The state will charge back to local government a share of the costs of carrying out the core public health functions in that community. (See RCW 43.70.130 and 70.05.130.)
6. Both stability and flexibility are necessary for state and local government public health financing.
 - a) Stable financing at an adequate level, which is both predictable and responsive to changes in the population, is required for carrying out the core public health functions.
 - b) Flexible financing, responsive to health assessment information including the degree and extent of public health threat, the effectiveness of prevention activities, and the community's priorities and values is required for public health activities which reflect policy choices of a community (e.g., anti-smoking education for youth, fluoridation of water supplies).
7. Additional state funding for local health jurisdictions shall not replace local government funding. (See RCW 43.70.58 and WAC 246.05.030.)
8. The state's methods of distributing funds to local health jurisdictions should consider local government's ability to support the core public health functions, local population characteristics, service cost delivery factors, and the nature and extent of community health risk and protective factors.

Fee Principles: Fees for service and permit functions have consistently made up about one-fifth of total local health jurisdiction revenues. Many activities with population based benefits are subsidized with local public funds. It is the responsibility and authority of the local board of health to decide which activities should be supported by fee revenue and to what degree, if any, they will be publicly subsidized.

A study of local health jurisdiction fee policies and practices found significant differences in how fees were being calculated, how services were being defined, and the degree to which similar services were being subsidized. Recognizing that setting fee policy is the authority of local government, the PHIP Steering Committee approved a set of principles for guiding the discussion and decision making that goes into creating and revising a local health jurisdiction fee schedule.

The Fee Principles are as follows:

- 1) Each local health jurisdiction should have a written fee policy that:
 - complies with RCW 70.05.060
 - describes a process of fee schedule development and frequency of review
 - describes a method for service cost calculation
 - describes a philosophy of service cost recovery
 - addresses the use of sliding fee scales
 - addresses fee collection practices

- 2) Prior to setting a fee, the service should be clearly defined, using standard definitions of practice when they exist. The actual cost of the service, including indirect cost, should be calculated using sound and consistent methodology.
- 3) Fee schedules should be routinely reviewed and revised. Hourly rates should be established to cover services not specified by the fee schedule.
- 4) Cost recovery from fees can vary by service and should be consistent with the local health jurisdiction's philosophy of service cost recovery. The following factors should be considered in setting a service fee:
 - If a service primarily benefits an individual or business, the cost recovery rate should be higher (e.g., reproductive health examination, food establishment certification).
 - If a service primarily benefits the population by protecting them from health problems or hazards, the cost recovery rate should be lower (e.g., childhood immunizations, on-site repair permit).
 - It should be taken into account that a high rate of cost recovery, for some services, may significantly influence practices and behaviors which put the public at risk of health problems(e.g., temporary food establishment permit, HIV counseling /testing).
- 5) Local government should have the primary responsibility for subsidizing services which have less than 100% cost recovery from fees, except when grant funding is specified to support a service.

The Department of Health developed descriptive instructions for local health jurisdictions to use in calculating actual costs of service provision and in the step-by-step process of establishing an fee schedule. These instructions became known as the "Fee Tool Box" and were approved by the PHIP Steering Committee for distribution to local health jurisdiction administrators in June 1996.

Appendix F. Measuring core functions and capacity

Sample Matrix
(Sample Capacity: Community Involvement)

Core Function	Standards of Performance and Capacity Standard Clusters Statements describing the capacity required at the local public health jurisdictional level to effectively carry out the core functions.	Indicators of Performance Measures of progress toward attaining the capacity required to effectively carry out the core functions.	Data Sources Places where information can be found regarding performance indicators.
Assessment			
Policy Development <i>Example: Community Involvement</i>	<i>Community health priorities are established through a community-wide process.</i>	<i>36. LHJ assures that leaders in health care, government agencies, and the general public are involved in determining priority public health issues in the community.</i>	<ul style="list-style-type: none"> • <i>Budget</i> • <i>Community assessment report</i> • <i>Community meeting minutes</i>
Administration			
Prevention			
Access & Quality			

The 88 core function capacity standards are clustered according to common functional and capacity elements. An overarching statement describes the “performance standard” for each cluster of capacity standards (Column 2). Thirty-nine performance indicators assess the degree to which each performance standard is achieved (Column 3). Suggested data sources are provided to assist local health jurisdiction personnel determine a score for the indicators (Column 4).

Each of the 39 indicators of performance contained in this matrix is scored using a 6 point measurement scale:

- | | |
|-------------------|--------------------|
| 0 - Don't know | 3 - Moderately met |
| 1 - Not met | 4 - Mostly met |
| 2 - Minimally met | 5 - Fully met |

Structure and Policies

Core Function	Standards of Performance (1994 Capacity Standards)	Indicators of Performance	Data Sources
Assessment	Policies, procedures, and legal authority guide the collection and use of data. (Capacity Standards 1, 2, 58, 61)	<ol style="list-style-type: none"> LHJ has identified procedures for information collection from data sources, the organization and analysis of information and the transmittal of findings to data users. LHJ has an established process to monitor and evaluate assessment activities to ensure their validity and accuracy. 	<ul style="list-style-type: none"> RCWs and WACs BOH by-laws BOH resolutions LHJ and DOH policies, procedures, and standards
Policy Development	Processes to develop public health policy are defined, applied, and consistent with legal authority. (Capacity Standards 3, 15, 16, 21, 22, 29, 30, 37, 41, 48, 65-68, 76, 78)	<ol style="list-style-type: none"> LHJ has an identified process, which it uses, to develop policies that are presented to the Board of Health. LHJ has an established system for the ongoing evaluation of priority public health issues. 	<ul style="list-style-type: none"> Policy and procedures manuals BOH policies Meeting minutes
Administration	Governance and management structures are in place that incorporate responsibilities and authorities of the Board of Health, Health Officer and Administrator. (Capacity Standards 15, 16, 19, 20-22, 29, 30, 35, 37, 38, 41, 43)	<ol style="list-style-type: none"> Legally constituted Board of Health meets at least quarterly in an open forum that facilitates community participation in the meetings. LHJ legal obligations such as compensation plans and contracts for services, are approved by the Board of Health. 	<ul style="list-style-type: none"> RCWs BOH meeting minutes Resolutions and motions adopted by BOH Health Officer appointed pursuant to RCW 70.05
Prevention	Community health services are based on the jurisdiction's explicit authority, Board of Health authorization, and internal policies. (Capacity Standards 15, 16, 22, 29, 64, 66, 67, 71, 73)	<ol style="list-style-type: none"> LHJ prevention and protection programs are approved by the Health Officer, Administrator and/or Board of Health. LHJ prevention and protection programs are reviewed annually to assure they meet the intent of the statutes, regulations and contractual requirements. 	<ul style="list-style-type: none"> Policy manuals Local ordinances BOH minutes Contracts Memoranda of understanding
Access and Quality	Policies, legal authority and community action plans guide the assurance of access and quality of community health services. (Capacity Standards 74, 75)	<ol style="list-style-type: none"> LHJ has identified practices to assure community access to, and quality of, health services including prevention and protection. 	<ul style="list-style-type: none"> Plans addressing access and quality. Policy and procedures manuals Job descriptions

Skills and Resources

Core Function	Standards of Performance (1994 Capacity Standards)	Indicators of Performance	Data Sources
Assessment	Assessment activities are performed by equipped and competent personnel. (Capacity Standards 1-7, 19, 23-25, 33, 34, 46, 50, 51, 58, 61, 65)	10. LHI has access to people technically skilled in carrying out assessment activities. 11. LHI acts to assure the availability of resources required to effectively perform assessment activities. 12. LHI provides opportunities for continuing education and peer support to staff involved in assessment activities.	<ul style="list-style-type: none"> • Job qualifications • Personnel records • Continuing education records
Policy Development	Policy options are developed by equipped and competent personnel. (Capacity Standards 9, 18-20, 23-25, 41, 47, 81)	13. LHI has access to people technically skilled in carrying out policy development activities. 14. LHI acts to assure the availability of resources required to effectively perform policy development activities. 15. LHI provides opportunities for continuing education and peer support to staff involved in policy development activities.	<ul style="list-style-type: none"> • Job qualifications • Personnel records • Continuing education records
Administration	Human resources, contracting and procuring systems assure public health functions are performed by trained, equipped, and competent personnel in accord with contractual and legal obligations. (Capacity Standards 1-4, 7, 18-25, 32, 34-36, 40-45, 47, 58, 62)	16. LHI has access to people technically skilled in carrying out administration activities. 17. LHI acts to assure the availability of resources required to effectively perform administration activities. 18. LHI provides opportunities for continuing education and peer support to staff involved in administration activities. 19. LHI has a written description of the personnel and financial management systems.	<ul style="list-style-type: none"> • Written staff development plans • Continuing education records • Personnel records • Job descriptions • Written performance appraisal system
Prevention	Prevention programs are managed by staff who are skilled and knowledgeable in community health services. (Capacity Standards 3, 9, 45, 46, 49, 50, 53-60, 62, 65, 68, 70, 80)	20. LHI has access to people technically skilled in carrying out prevention programs. 21. LHI acts to assure the availability of resources required to effectively perform prevention programs. 22. LHI provides opportunities for continuing education and peer support to staff involved in the core function of prevention.	<ul style="list-style-type: none"> • Personnel records • Job qualifications • Continuing education records
Access and Quality	LHI uses skilled and knowledgeable staff to monitor and maintain the quality of community health services and to assure access and quality of care in the community. (Capacity Standards 74, 75)	23. LHI has access to people technically skilled in carrying out the core function of access and quality. 24. LHI acts to assure the availability of resources required to effectively perform the core function of access and quality. 25. LHI provides opportunities for continuing education and peer support to staff involved in the core function of access and quality.	<ul style="list-style-type: none"> • Personnel records • Job qualifications • Continuing education records

Information and Communication

Core Function	Standards of Performance (1994 Capacity Standards)	Indicators of Performance	Data Sources
Assessment	Information systems enable the collection, use and communication of data. (Capacity Standards 1-5, 19, 23-28, 33, 34, 46, 50, 51, 58, 61, 65)	26. LHJ systematically distributes public health data to the community, providers, boards and organizations serving the community. 27. LHJ assures that the provider community receives information on new, revised and priority public health policies. 28. LHJ assures that Board of Health and staff members receive orientation to the role of LHJ in policy development.	<ul style="list-style-type: none"> • Policy and procedures manuals • Public relations documents, news releases, and presentation outlines
Policy Development	Public health policies are communicated within the public health community and to the community at large. (Capacity Standards 17, 18, 19, 28, 31, 34, 46, 50, 51, 86)	29. LHJ management information systems track financial and service data. 30. Data from management information systems are analyzed and information is developed for reporting to internal and external constituencies. 31. LHJs have the ability to communicate electronically with one another, the DOH and the CDC.	<ul style="list-style-type: none"> • Written orientation and training procedures • Evidence of orientation • News releases, and presentations
Administration	Information management enables oversight, planning, monitoring and periodic evaluation of department policies and services. (Capacity Standards 1, 2, 4, 7, 19, 23-35, 27, 28, 31, 33, 34, 38, 40, 42, 46, 51, 58, 61)	32. LHJ uses data acquired through the information systems in the development of health policy and the evaluation of prevention services.	<ul style="list-style-type: none"> • Management information system reports • State and local assessment data
Prevention	Prevention and protection services are consistent with community assessment and other data. (Capacity Standards 11, 33, 34, 51, 63, 72, 82, 84, 86)	33. Local health providers are informed annually of progress to improve health priorities and strategies related to access and quality. 34. LHJ information system collects and distributes data on access to, and quality of, health services in the community.	<ul style="list-style-type: none"> • Information systems reports • Project descriptions • Contracts • Project reports
Access and Quality	Local health jurisdiction and community providers collaborate on the collection and distribution of community health service data. (Capacity Standards 74, 76)		<ul style="list-style-type: none"> • Services utilization data • Annual reports • Agreements with local providers • Resource directory

Community Involvement

Core Function	Standards of Performance (1994 Capacity Standards)	Indicators of Performance	Data Sources
Assessment	Community is involved in the assessment of its health. (Capacity Standards 3, 5, 6, 19, 23-28, 46, 50, 51)	35. LHJ provides opportunities to involve the community in the development of methods used to determine the extent and magnitude of local public health problems.	<ul style="list-style-type: none"> • Policy and procedures manuals • Community meeting minutes
Policy Development	Community health priorities are established through a community-wide process. (Capacity Standards 6, 17, 25, 26, 27, 28, 48, 51, 61, 78)	36. LHJ assures that leaders in health care, government agencies, and the general public are involved in determining priority public health issues in the community.	<ul style="list-style-type: none"> • Budget • Community meeting minutes • Community assessment report
Administration	Financial practices support community priorities and community involvement. (Capacity Standards 17, 23, 26, 28, 32, 39, 48, 61)	37. LHJ budget, reviewed and adopted by the Board of Health in a public process, reflects public health priorities.	<ul style="list-style-type: none"> • Meeting minutes • BOH resolutions
Prevention	Public health promotion and protection activities are appropriate for the community. (Capacity Standards 5, 25-28, 48, 61)	38. LHJ identifies and collaborates with constituent groups to address priority health promotion and protection needs in the community.	<ul style="list-style-type: none"> • Affiliation agreements • Contracts • Meetings minutes
Access and Quality	The combined efforts of the local health jurisdiction and the community are effective in assuring access to, and quality of, local health services. (Capacity Standard 76)	39. LHJ provides coordination, direction and leadership within the community to improve the access to, and quality of, health services.	<ul style="list-style-type: none"> • Community mailing lists • Community meeting minutes • Program reports

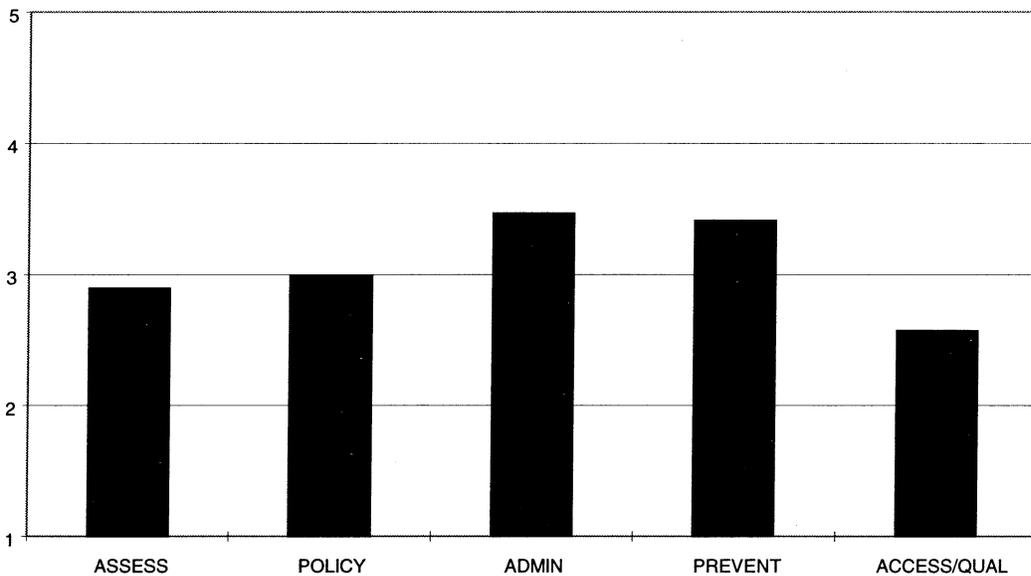
- The core functions of Administration and Prevention are reported by local jurisdictions as being most successfully met, while Access and Quality is scored lowest of the five functions.

Figure 1

- 1- Not met
- 2- Minimally met
- 3- Moderately met
- 4- Mostly met
- 5- Fully met

Core Function Performance

Assessment of community needs; development of public health **policy**;
public health **administration**; **prevention**, protection, and health
promotion; and assuring **access** to and **quality** of health services

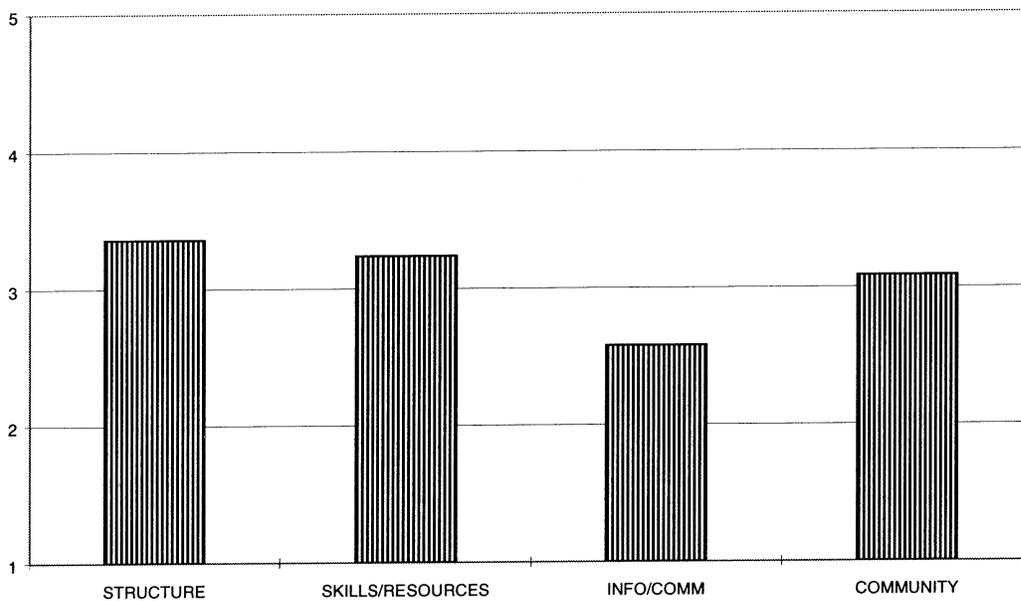


The Structure and Policy capacity is reported as being the most fully developed of the four capacity elements. It is followed, in order, by Skills and Resources, Community Involvement and Information and Communication.

Figure 2

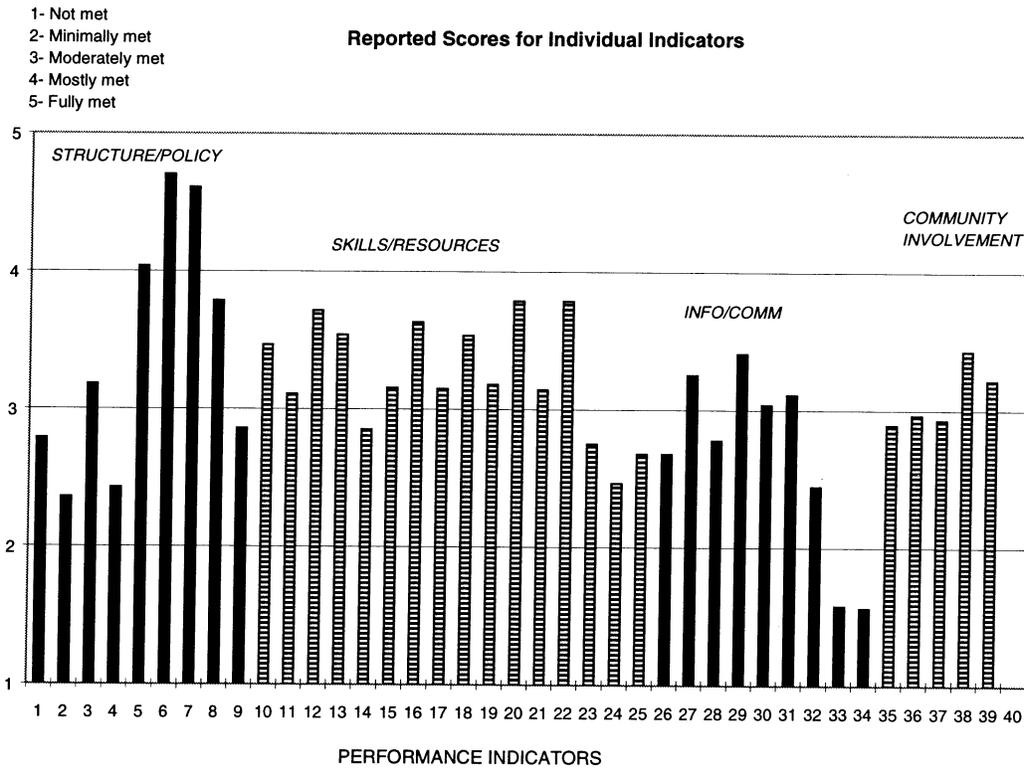
- 1- Not met
- 2- Minimally met
- 3- Moderately met
- 4- Mostly met
- 5- Fully met

Availability of Basic Public Health Capacity
structure and policies; skills and resources; information and communication systems; and
involvement with the community.



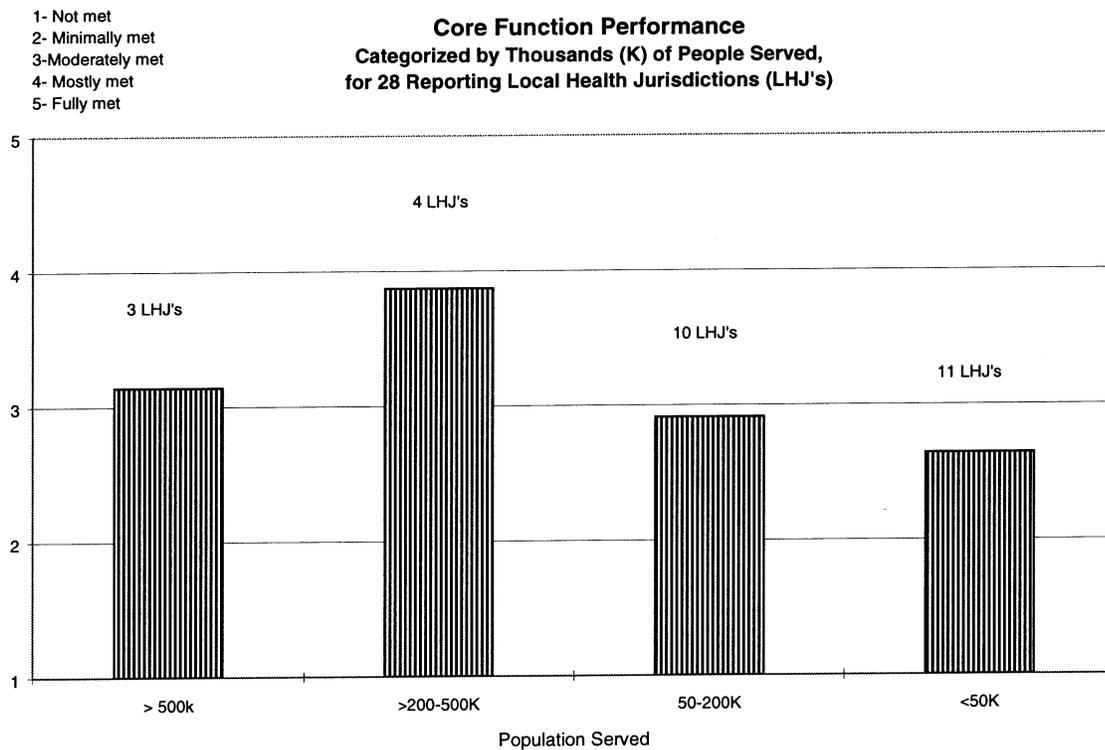
- Results for the 39 indicators scored by local public health jurisdictions show that Structure and Policy (Indicators 1-9) has the greatest range of variability among indicators, having a high score of 4.7 for Indicator 6 and a low score of 2.4 for Indicator 2.

Figure 3



- Results of the 1996 survey show that those jurisdictions serving between 200 and 500 thousand people score highest on the 1-5 scale with a mean score of 3.9. Those jurisdictions serving less than 50 thousand reported an mean score of 2.6.
- Three local public health jurisdictions serve a population of more than 500,000, representing 52% of the state's population;
- Four jurisdictions serve between 200-500 thousand people, representing 21% of the state's population;
- Thirteen jurisdictions serve 50-200 thousand, representing 22% of the state total; and
- Thirteen jurisdictions serve less than 50,000 persons, and represent 5% of the state's population.

Figure 4



Appendix G. Core Function Capacity Standards

These capacity standards differ slightly from those in the 1994 PHIP. They were revised to improve clarity and specificity and to be consistent with current law. One standard has been added to “Administration” (no. 35) and two have been deleted in “Access and Quality”.

Health Assessment

Health assessment means the regular collection, analysis and sharing of information about health conditions, risks and resources in a community. Assessment activities monitor, analyze and evaluate community health status, risk indicators and, when necessary, health emergencies. They identify trends in illness, injury, and death and the factors which may cause these events. They also identify environmental risk factors, community concerns, community health resources, and the use of health services. Assessment includes gathering statistical data as well as conducting epidemiologic and other investigations.

Assessment Capacity Standards

All public health jurisdictions, both state and local, must:

1. Have access to an integrated, centrally managed electronic network that provides access to federal, state and local information systems.
2. Develop, operate, and assure the quality of data management systems which meet local needs in order to systematically collect, analyze, and monitor standardized baseline data.
3. Conduct and publicize epidemiologic, sociologic, economic, and other investigations which assess the health of the community and access to health care. Assure that investigation and communication methods are sensitive to individual, family and community needs, values, language, and cultural differences. Help develop and evaluate prevention and control measures, research strategies, and policy options.
4. Link with local and statewide data bases, such as vaccination registries, CDC INPHO system, vital records, and community hospital information systems.

Each local public health jurisdiction must:

5. Conduct a regular community health assessment, using a standardized format such as the Assessment Protocol for Excellence in Public Health (APEX/PH).
6. Identify barriers in a community related to transportation, language, culture, education, information, and service delivery systems design that affect access to health services, especially for low income and other special populations.
7. Assure access to high quality, cost-effective, timely environmental and clinical laboratory services which support outbreak investigations and meet routine diagnostic and surveillance needs.

The **state** must:

8. Develop community data standards as well as statewide standards for data use and dissemination. This should be a collaborative process with the Health Care Policy Board, health service purchasers, and the public health system. This includes standardized approaches to health status indicators, geographic information systems, population data, and biostatistical calculations.
9. Provide consultation and technical assistance to ensure a high standard of data analysis, dissemination, and risk communication.
10. Implement a fully integrated, secure statewide computer network that will include electronic mail, accessibility to documents and files, as well as the ability to access and amend basic data systems.
11. Evaluate and disseminate information regarding new health and information technologies. In collaboration with organizations such as the Health Care Policy Board, CDC, State Board of Health, and health professions associations.
12. Survey the statewide availability of clinical and environmental laboratory services and help local health jurisdictions track this information.
13. Provide a public health laboratory which is closely integrated with the needs and requirements of state and local health jurisdictions.
14. Assess the supply and distribution of health care providers, facilities and services.

Policy Development

A goal of the *Public Health Improvement Plan* is to assure that, at both state and local levels, policies are developed, implemented, and evaluated in a comprehensive manner that incorporates both qualitative and quantitative scientific information and community values.

The most effective public health jurisdictions are supported by the communities they serve. It is, after all, the people of any community who make the daily decisions which determine the health of the community. Residents who seek better health can organize themselves toward that end. Public health jurisdictions with the capacity to empower communities can assist in this effort.

This capacity requires the ability to listen to residents who understand the strengths and weaknesses of those who live in the community. It requires the ability to prioritize work according to the needs of those in the community and build from their strengths rather than from institutional strengths.

Public health policy is established through processes involving many individuals and organizations, including state and local boards of health, elected officials, community groups, public health professionals, health care providers, and citizens. Public health jurisdictions must have the legal authority to make and implement policy decisions. Decision makers must evaluate information from health assessment activities and listen to the concerns expressed by community members.

Public health jurisdictions must be able to evaluate both planned and current policies. In order to do this they must have the technical ability and resources to provide authorized decision makers with periodic information and data analyses regarding specific health issues. They must also have a system to facilitate community involvement and inform community members on a regular basis. State and local public health jurisdictions must have a similar framework for policy development activities, allowing for differences that result from their respective scope of responsibilities.

Policy Development Capacity Standards

All public health jurisdictions, both state and local, must:

Authority

15. Develop explicit and formal statements of the public health jurisdiction's legal authority to develop, implement, and enforce public health policy.

Policy Analysis and Formulation

16. Enact policies and procedures within the existing legal scope of authority. There are two kinds of authority: authority granted to state and local boards of health to enact rules, and authority to make decisions regarding those issues which do not require action by a board of health.
17. Involve the community in developing and analyzing policies related to the community's strategic plan and the jurisdiction's policy and planning activities.
18. Develop, analyze, and communicate alternative policies.
19. Provide accurate, timely, understandable information and data to policy makers, community leaders, and health care providers with emphasis on identifying threshold standards which have been exceeded. This includes technical support to decision makers to help them anticipate the effect of regulations, budget decisions, and policies on the community or the state as a whole.
20. Provide legal counsel to review policy decisions.
21. Promote state and local legislation and regulation aimed at reducing public health risk factors and promoting healthy behaviors. Evaluate current legislation and regulation to determine if it supports these goals.

Policy Implementation

22. Translate enacted policies into operating program procedures including:
 - Clarify or establish the legal basis and authority that are required to proceed with implementation.
 - Define and estimate the costs of personnel, equipment, and facilities associated with procedures that have been developed.
23. Estimate costs and effects of proposed policies, *secure resources to support these policies*, and inform affected parties and the community.

Policy Evaluation

24. Identify policy outcomes, develop outcome measures, evaluate them on a regular basis, and communicate the findings.

25. Evaluate program efforts:
 - To assure that they address community needs and problems.
 - To assess the relative efficacy, costs and benefits between specific prevention programs as well as between prevention programs and medical treatment.

Community Collaboration and Mobilization

26. Mobilize the community, and in particular health care providers, in a systematic and periodic process to set community priorities, develop policies and formulate strategies to address key public health problems based on the Community Assessment.
27. Collaborate with community members and health care providers to inform the public about the current health status of the community, using formats appropriate to the needs of various individuals or organizations.
28. Provide information and data, as requested and appropriate, and in keeping with confidentiality requirements, to interested community groups for health related activities.

Administration

To carry out its mission, and form successful community partnerships, each jurisdiction must have a clear administrative structure which supports the core public health functions. Effective administration is a critical element of all efforts to improve and promote community health. It involves a number of important features, including leadership, planning and financial and organizational management. All of the capacity standards assume that an effective administrative structure is in place. This is especially true of Policy Development, which includes key standards concerning community leadership and planning. Responsibilities related to the internal workings of the public health jurisdiction require the same leadership and management skills: agency and division directors must clearly assign responsibilities, delegate authority, and develop operating policies and procedures.

Administration Capacity Standards

All public health jurisdictions, both state and local, must:

Agency Management

29. Secure policy board authorization for operation of programs.
30. Periodically assess the role of other units of government within the agency's jurisdiction and their respective authority to implement public health policies to improve and promote community health.
31. Regularly collect and analyze information describing agency and program administration, funding, activities, workloads, client characteristics, and service costs.
32. Develop a long range strategic plan and time-limited, measurable agency and program objectives.

33. Assure the collection, analysis, and use of information that is needed to evaluate the outcome of program activities on risk and protective factors and health status.
34. Maintain a management information system and electronic communication capacity that allows the analysis of administrative, demographic, epidemiologic, and service utilization data to provide information for planning, administration, and evaluation.
35. Participate in agreements with other jurisdictions, as appropriate, to manage costs.
36. Secure and maintain qualified administrative and health officer leadership.

Financial Management

37. Designate a person who is responsible to oversee all financial responsibilities of the health jurisdiction.
38. Develop and implement a long term financial plan (i.e., extends beyond the operating budget cycle) that is consistent with the strategic plan identified in Standard 32.
39. Develop and implement budgets which reflect jurisdictional priorities and programs, address health problems, and assure that expenditures follow the budget and financial plan.
40. Involve professional and community groups in development, presentation, and justification of the budget.
41. Develop and manage contracts to provide public health services to or for community organizations, private nonprofit corporations, and health care organizations.
42. Assure that the policy board and staff understand their legal accountability and liability, as well as their general responsibility to the public for wise financial management.

Personnel Management

43. Have a comprehensive system of personnel management that complies with appropriate federal, state, and local regulations, including documenting relationships with other units or departments of government which carry out personnel functions of the public health jurisdiction.
44. Have an established working relationship and labor agreement between the health jurisdiction policy board and, where applicable, each labor union representing staff.
45. Maintain a salary administration plan, authorized by the policy board and designed to attract and retain competent staff.
46. Develop and implement a staffing plan which includes recruitment and retention strategies and professional development opportunities.

Prevention

The heart of public health is prevention of disease, injury, disability, and premature death. Prevention includes:

- **Primary** prevention, which reduces susceptibility or exposure to health threats. Immunizations are an example of primary prevention.
- **Secondary** prevention, which most often detects and treats disease in early stages. A program to encourage the use of mammograms to detect breast cancer is an example of a secondary prevention activity.
- **Tertiary** prevention, which alleviates some of the effects of disease and injury through such means as habilitation and rehabilitation.

Preventive services are provided both one-on-one in clinical settings and to groups of people in the community. The primary focus of public health prevention is to protect entire communities or populations from such threats as communicable diseases, epidemics and environmental contaminants.

Certain personal clinical personal health services are included in the standards because they benefit both the individual and the community. Immunizations, reproductive services, and communicable disease screening and treatment are examples of services which are of public health significance. The absence of these services can have wide ranging effects for the community as a whole.

Two main components of primary prevention are health *promotion* and health *protection*.

Health Promotion

Health promotion includes health education and the fostering of healthy living conditions and lifestyles. Health promotion activities may be directed toward individuals, families, groups, or entire communities. They help people identify health needs, obtain information and resources, and mobilize to achieve change. They foster an environment in which the beliefs, attitudes, and skills represented by individual behavior and the community norms are conducive to good individual and community health.

Health promotion includes communicating surveillance and epidemiologic data to public health officials, other health providers, industries, and the community as a whole. It includes working with communities on an ongoing basis to communicate relevant information, helping their mobilization efforts, and providing technical assistance and consultation.

Health Promotion Capacity Standards

All public health jurisdictions, both state and local, must:

47. Assure that the public is informed of the health status of the community, relevant health issues, and that education is provided regarding positive health behavior.

48. Assure the development and provision of culturally, linguistically and age appropriate health promotion programs for community health priorities.
49. Collaborate with public and private agencies, health care purchasers and providers to develop strategies to address public health risk factors.
50. Assure provision of services which enhance healthy family relationships and child growth and development.
51. Provide education and information to the general public about communicable and non-communicable diseases of public health importance.

Each **local public health jurisdiction** must:

52. Maintain an information and referral system concerning available health facilities, resources, and services.

The **state** must:

53. Provide health promotion models to address public health risk factors.
54. Assure that health promotion programs addressing health risk factors and positive healthy behaviors are implemented statewide consistent with locally identified health priorities, by providing technical assistance and program support.
55. Assure that continuing education programs are available that address disease and injury prevention to meet the specific needs of caregivers, health and facilities professionals, and other public and private partners.
56. Promote the use of K-12 school health education curricula.

Health Protection

Health Protection refers to those population-based services and programs that control and reduce the exposure of the population to environmental or personal hazards, conditions, or factors that may cause disease, disability, injury, or death. Health protection also includes programs that assure public health services are available on a 24 hour basis to respond to public health emergencies and coordinate responses of local, state, and federal organizations.

Health protection includes immunization, communicable disease surveillance and outbreak investigations, water purification, sewage treatment, control of toxic wastes, inspection of restaurant food service, and numerous other activities that protect people against injuries and occupational or environmental hazards.

Health protection activities occur throughout the community, in homes, schools, recreation and work sites. Because of this variability, and the shared responsibility for safety, health protection activities require collaboration with many community partners.

Health Protection Capacity Standards

All public health jurisdictions, both state and local, must:

57. Perform monitoring, inspection, intervention, and enforcement activities that eliminate or reduce the exposure of citizens to communicable disease and environmental hazards in both routine and emergency situations.
 - Develop protection programs, in accordance with federal guidelines and scientifically identified risk factors, that address priority health risk factors.
 - Assure that communicable disease contact investigation and follow-up is performed in a timely and appropriate manner, in adherence to guidelines of the federal Centers for Disease Control and Prevention.
 - Assure that persons identified to have communicable diseases are given information about treatment protocols, provided with prompt and effective treatment, when available, and advised about appropriate behavioral changes to reduce the risk of disease transmission.
58. Assure that individuals, especially children, are immunized according to recommended public health schedules.
59. Assure the surveillance, diagnosis, and treatment of communicable diseases of public health significance.
60. Assure the provision of public health services which affect the community and high risk populations, including:
 - Consultation and education services to day care centers and schools;
 - Intervention with high risk families to provide standardized screening and assessment, education, counseling and referral (such as NCAST, Minnesota Parenting Inventory, Region X Child Health Standards);
 - Community education on risk and harm reduction behavior;
 - Outreach to individuals not accessing care.
61. Assure provision of reproductive health services in the community.
62. Collaborate with communities in developing local and statewide emergency response plans, including mobilizing resources to control or prevent illness, injury or death.
63. Provide ongoing public health staff training in emergency response plans, including participation in practice exercises on a routine basis.
64. Provide 24 hour telephone access to respond to public health emergencies.
65. Conduct inspections, monitoring activities, and compliance strategies consistent with state and local board of health rules and regulations.

Each local public health jurisdiction must:

66. Identify and control potential and actual hazards to public health, such as maintaining a safe water system, ensuring safe food handling practices in restaurants, and managing toxic spills.

The **state** must:

67. Coordinate with federal rule making agencies and the Congress to assure that they take into account the effects of federal rules and statutes on the health risks, protection needs, and resources of Washington State.
68. Develop, in cooperation with *local* health jurisdictions and health care providers, statewide regulations and policies which guide the public health activities of direct service providers, the local public health jurisdictions, and state agencies.
69. Carry out direct regulatory responsibilities in environmental health programs, including those imposed by federal mandate, which are not addressed by local jurisdictions.
70. Assist communities in developing emergency medical and trauma care services to provide immediate access to life saving interventions for illness or injury.
71. Support and assist local agencies' crisis response efforts:
 - Support local health agencies in the provision of laboratory services, food and water inspection, radiological assessment, and disease identification and testing during emergencies.
 - Help coordinate the transfer of needed personnel, resources, and equipment to emergency sites.
72. Designate the Department of Health as the lead agency, in the Washington State Comprehensive Emergency Management Plan, for coordinating all public health activities during emergencies.
73. Provide public information support to the Office of the Governor and to other state or federal emergency management agencies during emergency and disaster recovery operations.
74. Help coordinate and incorporate local emergency response plans into the Washington State Comprehensive Emergency Management Plan.

Access and Quality

Public health jurisdictions monitor and maintain the quality of public health services and participate in monitoring the quality of health and social services through credentialing and discipline of health professionals, licensing of facilities, and enforcement of standards and regulations. They also have a role to play in assuring that all residents have access to health services.

Efforts to assure access and quality of care require partnerships among many affected parties, sharing of data, and tracking of measurements, programs, and changes over time. They require ongoing efforts to obtain community and client perspectives on quality of care or services received.

Access and Quality Capacity Standards

Each **local public health jurisdiction** must:

75. Assure that prevention and intervention efforts (including treatment) for communicable diseases and other public health conditions, are being appropriately implemented.

76. Assure the competence of food handlers, solid and hazardous waste generators, on-site sewage system designers, and other individuals whose activities fall within the public health authority of the local health jurisdiction.
77. Collaborate with health care providers and other community service agencies to reduce barriers to accessing health care and to assure that individuals and families are linked with health services.

The **state** must:

78. Assure access to personal primary and preventive health services. This includes:
 - Providing policy, financial, and technical support to help improve access;
 - Supporting community efforts to address unmet health needs;
 - Collaborate with health care training programs, professional organizations, health care providers, and community leaders to assure an adequate supply and distribution of high quality provider services.
79. Establish criteria to assess the competency of health professionals as well as design, implement, and evaluate credentialing and certification methods for health professionals, facilities and providers of other public services.
80. Assure that local health jurisdictions, contractors (including state funded public health programs), health care sites and providers comply with appropriate regulations and standards, and meet contractual obligations.
81. Promote best practices through the use of professionally adopted standards of care.
82. Assure that health care and public health providers have access to and use on-going training.
83. Conduct quality assurance activities and operate state-mandated regulatory programs necessary to ensure that all laboratories produce high quality outcomes. Work with agencies to correct deficiencies and provide appropriate training programs.
84. Improve the analytical performance of clinical and environmental laboratories through training, consultation, technology transfer, and regulation.
85. Promote the ongoing use of utilization review, treatment outcome research, and performance-based program evaluations to achieve continuous quality improvement in public health and medical care services.
86. Evaluate health system work force trends and determine effect on access to health care.
87. Designate the Department of Health as the primary advocate, along with other state agencies and public entities whose activities are intended to improve health status, to develop policies and programs which are consistent with population-based approaches to community health status improvement.

Appendix H. Tribal health and the Centennial Accord

Tribal public health in Washington

The provision of health care to American Indians is an obligation of the federal government stemming from treaties with sovereign Indian tribes and subsequent federal legislation and court decisions. Although the federal government has acknowledged its obligation, congressional appropriations have consistently fallen short of fully funding this responsibility.

American Indians are members of tribes, as well as citizens of the United States and residents of Washington State. Since 1955, the Indian Health Service (IHS) has administered the federal Indian health programs. Federal IHS funding for Indian care is the payor of last resort and often does not meet the basic health needs of Indian people. Over the past two decades, Indian tribes and urban Indian organizations have become increasingly determined to correct inadequacies in the delivery of health care to American Indians. Now, most Indian health programs in Washington state are tribally managed under the principles of tribal self-determination and self-governance.

Indian health programs are organized under a community-based primary care model that strives to functionally integrate public health services and clinical health care under a single system. Tribes provide services with an American Indian holistic view of health and with respect for the tribe's culture, values, and practices. The governing authority usually rests with the tribe's elected officials, the tribal council. Some tribal councils have appointed a health board (authority or commission) to govern their clinical and public health programs. Most tribes provide, to some degree, community health nursing, health education, environmental sanitation, school health, maternal and child health, tuberculosis control, and other communicable disease programs.

There are 27 federally recognized tribes in Washington State, including the Chehalis Tribe, Colville Confederated Tribes, Hoh Tribe, Jamestown S'Klallam Tribe, Kalispel Tribe, Lower Elwha Klallam Tribe, Lummi Nation, Makah Tribe, Muckleshoot Tribe, Nisqually Tribe, Nooksack Tribe, Port Gamble S'Klallam Tribe, Puyallup Tribe, Quileute Tribe, Quinault Nation, Samish Tribe, Sauk-Suiattle Tribe, Shoalwater Bay Tribe, Skokomish Tribe, Spokane Tribe, Squaxin Island Tribe, Stillaguamish Tribe, Suquamish Tribe, Swinomish Tribe, Tulalip Tribes, Upper Skagit Tribe, and Yakama Indian Nation. The tribal enrollments range from a low of 123 to a high of over 9,000. The median size is 750. Land area ranges from as little as a few acres to about 1.4 million acres (see map, Appendix A) for the largest two tribes (Colville and Yakama).

Indian health programs are financed through the combination of tribal revenue, federal funding, third-party collections, and some limited public and private categorical grants. The majority of American Indians using Indian health programs do not have insurance, Medicaid, or other third party coverage. For this group, most tribes have only the resources to contract for emergency or urgent care or hospitalization. At the same time, the health status of the 107,000 (OFM Forecasting, 1996) American Indian people living in Washington State is very poor, with high rates of some causes of mortality and infectious disease and limitation of major activities due to chronic health problems. In 1994, Indian infants in Washington were about twice as likely as white infants to die in infancy.

In addition to maintaining a government-to-government relationship with Washington's federally recognized tribes in keeping with the Centennial Accord of 1989, the Department of Health collaborates with the American Indian Health Commission for Washington State. Established in 1994, this consortium of federally recognized tribes, urban Indian health programs, and individual American Indians and Alaskan Natives has played a pivotal role in opening communication with the Department of Health and other state

agencies by serving as a forum to address health-related issues and to negotiate policy formulation. It is the commission's policy to seek consensus and provide guidance to the state regarding the collective needs of its members to assure quality and comprehensive health care to Indian people in Washington. The commission does not circumvent the sovereign authority of the tribal governments. It usually meets every other month and coordinates an annual Tribal Leaders Health Summit.

In 1995, a Tribal Leaders Health Summit was held and the following public health goals were adopted: 1) Improving the health status of the tribe; 2) assuring the delivery of culturally appropriate services to Indian people; and 3) preserving tribal sovereignty. In pursuit of these goals, tribes interpret and analyze each policy question through the lens of tribal sovereignty, culture, and experience, and not on the simple calculation of the cost or funding.

From the Tribal Leaders Health Summit, the American Indian Health Commission for Washington State proposed five different options in which improved public health services could be provided to tribal communities. In all options, tribal governments would maintain their sovereign powers to develop policies, set priorities, and assure the quality and effectiveness of services. Responsibility for providing specific services could remain with each tribal government or be delegated to another governmental entity. These options should be analyzed to understand their implications.

1. Primary responsibility to provide public health services lies with the tribal government with options to sub-contract with state or county providers. This is an option for tribes that have the capacity to provide a wide range of core public health services.
2. Primary responsibility to provide public health services is with the state government. This option may be desirable for tribes with more than one county within the external boundaries of their reservations.
3. Primary responsibility to provide public health services is with county government. This option may be acceptable to tribes who have established a mutually beneficial government-to-government relationship with the county within the external boundaries of their reservations, or a tribe that has limited capacity to provide public health services.
4. Primary responsibility to provide public health services is with the state and county governments depending on the service component. This option may be appropriate for a tribe during its capacity building period when a services provider relationship may be necessary with both entities.
5. Primary responsibility to provide public health services is with the federal government. This option represents a traditional federal relationship which some tribes may wish to continue.

Centennial Accord between the Federally Recognized Indian Tribes in Washington State and the State of Washington

I. Preamble and Guiding Principles

This Accord dated August 4, 1989, is executed between the federally recognized Indian tribes of Washington signatory to this Accord and the state of Washington, through its governor, in order to better achieve mutual goals through an improved relationship between their sovereign governments. This Accord provides a framework for that government-to-government relationship and implementation procedures to assure execution of that relationship.

Each Party to this Accord respects the sovereignty of the other. The respective sovereignty of the state and each federally recognized tribe provide paramount authority for that party to exist and to govern. The parties share in their relationship particular respect for the values and culture represented by the tribal governments. Further, the parties share a desire for a complete accord between the State of Washington and the federally recognized tribes in Washington reflecting a

full government-to-government relationship and will work with all elements of state and tribal governments to achieve such an accord.

II. **Parties**

There are twenty-six federally recognized Indian tribes in the state of Washington. Each sovereign tribe has an independent relationship with each other and the state. This Accord, provides the framework for that relationship between the State of Washington, through its governor, and the signatory tribes.

The parties recognize that the state of Washington is governed in part by independent state officials. Therefore, although, this Accord has been initiated by the signatory tribes and the governor, it welcomes the participation of, inclusion in and execution by chief representatives of all elements of state government so that the government-to-government relationship described herein is completely and broadly implemented between the state and the tribes.

III. **Purposes and Objectives**

This Accord illustrates the commitment by the parties to implementation of the government-to-government relationship, a relationship reaffirmed as state policy by gubernatorial proclamation January 3, 1989. This relationship respects the sovereign status of the parties, enhances and improves communications between them, and facilitates the resolution of issues.

This Accord is intended to build confidence among the parties in the government-to-government relationship by outlining the process for implementing the policy. Not only is this process intended to implement the relationship, but also it is intended to institutionalize it within the organizations represented by the parties. The parties will continue to strive for complete institutionalization of the government-to-government relationship by seeking an accord among all the tribes and all elements of state government.

This Accord also commits the parties to the initial tasks that will translate the government-to-government relationship into more efficient, improved and beneficial services to Indian and non-Indian people. This Accord encourages and provides the foundation and framework for specific agreements among the parties outlining specific tasks to address or resolve specific issues.

The parties recognize that implementation of the Accord will require a comprehensive educational effort to promote understanding of the government-to-government relationship within their own governmental organizations and with the public.

IV. **Implementation Process and Responsibilities**

While this Accord addresses the relationship between the parties, its ultimate purpose is to improve the services delivered to people by the parties. Immediately and periodically, the parties shall establish goals for improved services and identify the obstacles to the achievements of those goals. At an annual meeting, the parties will develop joint strategies and specific agreements to outline tasks, overcome obstacles and achieve specific goals.

The parties recognize that a key principle of their relationship is a requirement that individuals working to resolve issues of mutual concern are accountable to act in a manner consistent with this Accord.

The state of Washington is organized in a variety of large but separate departments under its governor, other independently elected officials and a variety of boards and commissions. Each tribe, on the other hand is a unique government organization with different management and decision-making structures.

The chief of staff of the governor of the state of Washington is accountable to the governor for implementation of this Accord. State agency directors are accountable to the governor through the chief of staff for the related activities of their agencies. Each director will initiate a procedure within his/her agency by which the government-to-government policy will be implemented.

Among other things, these procedures will require persons responsible for dealing with issues of mutual concern to respect the government-to-government relationship within which the issue must be addressed. Each agency will establish a documented plan of accountability and may establish more detailed implementation procedures in subsequent agreements between tribes and the particular agency.

The parties recognize that their relationship will successfully address issues of mutual concern when communication is clear, direct and between persons responsible for addressing the concern. The parties recognize that in state government, accountability is best achieved when this responsibility rests solely within each state agency. Therefore, it is the objective of the state that each particular agency be directly accountable for implementation of the government-to-government relationship in dealing with issues of concern to the parties. Each agency will facilitate this objective by identifying individuals directly responsible for issues of mutual concern.

Each tribe also recognizes that a system of accountability within its organization is critical to successful implementation of the relationship. Therefore, tribal officials will direct their staff to communicate within the spirit of this Accord with the particular agency which, under the organization of state government, has the authority and responsibility to deal with the particular issue of concern to the tribe.

In order to accomplish these objectives, each tribe must ensure that its current tribal organization, decision-making process and relevant tribal personnel is known to each state agency with which the tribe is addressing an issue of mutual concern. Further, each tribe may establish a more detailed organizational structure, decision-making process, system of accountability, and other procedures for implementing the government-to-government relationship in subsequent agreements with various state agencies. Finally, each tribe will establish a documented system of accountability.

As a component of the system of accountability within state and tribal governments, the parties will review and evaluate at the annual meeting the implementation of the government-to-government relationship. A management report will be issued summarizing this evaluation and will include joint strategies and specific agreements to outline tasks, overcome obstacles, and achieve specific goals.

The chief of staff also will use his/her organizational discretion to help implement the government-to-government relationship. The Office of Indian Affairs will assist the chief of staff in implementing the government-to-government relationship by providing state agency directors information with which to educate employees and constituent groups as defined in the accountability plan about the requirement of the government-to-government relationship. The Office of Indian Affairs shall also perform other duties as defined by the chief of staff.

V. Sovereignty and Disclaimers

Each of the parties respects the sovereignty of each other party. In executing this Accord, no party waives any rights, including treaty rights, immunities, including sovereign immunities, or jurisdiction. Neither does this Accord diminish any rights or protections afforded other Indian persons or entities under state or federal law. Through this Accord parties strengthen their collective ability to successfully resolve issues of mutual concern.

While the relationship described by this Accord provides increase ability to solve problems, it likely will not result in a resolution of all issues. Therefore, inherent in their relationship is the right of each of the parties to elevate an issue of importance to any decision-making authority of another party, including where appropriate, that party's executive office.

Signatory parties have executed this Accord on the date of August 4, 1989, and agreed to be duly bound by its commitments.

Appendix I. Biographies of PHIP Steering Committee members and staff

Development and implementation of the PHIP is overseen by a broad-based steering committee which includes representation from business, labor, the Legislature, tribal government, public health professionals, the state Board of Health, the Health Care Policy Board, education, consumers, local and state government agencies, and health care providers. Technical advisory committees comprised of experts in the fields of public health, management, finance, and governance have developed and proposed portions of the plan for steering committee consideration.

John A. Beare

Spokane, representing the Washington State Public Health Association. John has served as Health Officer for Spokane County Health District for seven years. Over the 25 previous years, he held various administrative positions in the Health Division of the State Department of Social and Health Services and the former State Department of Health, including Director and Assistant Secretary, and Acting and Deputy Assistant Secretary. From 1974 through 1996 he has been Clinical Professor of Health Services, University of Washington School of Public Health and Community Medicine. Memberships and public service include American Public Health Association, Washington State Public Health Association, Spokane County Medical Society, Washington State Medical Association, Washington State Association of Local Public Health Officials, State Board of Health, Washington Traffic Safety Commission, National Drinking Water; Drinking Water Advisory Committee, President and member of the Executive Committee of Association of State and Territorial Health Officials and AIDSNET Director's Council. He holds a Doctor of Medicine, a Master of Public Health, and a Bachelor of Science.

Bobbie Berkowitz

Olympia, Public Health Improvement Plan Steering Committee chair. Bobbie joined the faculty at the University of Washington School of Public and Community Medicine in July, 1996 as Deputy Director of The Robert Wood Johnson Foundation "Turning Point" National Program Office. She came to the University of Washington from the Washington State Department of Health where she served as Deputy Secretary from May 1993 until July 1996. Prior to that, she served as Chief of Nursing Services for the Seattle-King County Department of Public Health. She currently holds a Senior Lecturer appointment with the Department of Health Services at the University of Washington School of Public Health and Community Medicine and an Assistant Professor appointment with St. Martin's College Department of Nursing. She also holds an Assistant Clinical Professor appointment with Seattle University School of Nursing. Bobbie served on the Washington State Board of Health from 1988 to 1993. She was appointed by the Governor to the Washington Health Care Commission from 1990 through 1992 where she served as Chair of the Health Services Committee. Bobbie is a member of the Board of Directors for the Hanford Environmental Health Foundation and serves on the Editorial Advisory Board of the journal, Public Health Nursing. Bobbie is a Fellow in the American Academy of Nursing and currently co-chairs the Institute of Medicine Committee on Public Health Performance Monitoring. She holds a Ph.D. in Nursing Science from Case Western Reserve University, and Master of Nursing and Bachelor of Science in Nursing from the University of Washington.

Dennis Braddock

Seattle, representing the Community Health Plan of Washington. Dennis is Executive Officer of Community Health Plan of Washington as well as principal and owner of a land use planning consulting firm. From 1983 to 1993, he served in the State House of Representatives where, as Health Care Committee Chair, he worked to develop House positions on a wide range of health care issues and worked for health system reform. Legislation he sponsored included Statewide Trauma System Reform, Omnibus AIDS Bill, Pre-natal Care Legislation, Long Term Care Reform Bill, Health Care Reform Legislation and creation of the Health Care Commission. He was Vice Chair of the Ways and Means Committee and Chair of the Capital Budget Committee. Dennis received a Bachelor of Arts in Political Science from Washington State University.

Margaret M. Casey

Olympia, representing public health consumers. For over 20 years, Margaret has successfully lobbied the Washington State Legislature on family issues, long term care issues, labor, housing, human and civil rights, education, juvenile and adult corrections, and sentencing reform. She has also lobbied for selected issues at the Congressional level. Much of Margaret's work has been for organizations that support public health, such as the Anti-hunger and Nutrition Coalition, the Children's Alliance, Washington School Food Service Association, Washington State Association for Adult Day Centers and Washington Chore and Home Care Coalition. Margaret has also worked as a teacher and principal. She received a Master of Arts in Educational Administration, and a Bachelor of Arts from Seattle University.

Dorothy Elaine Conley

Marysville, representing the Public Health Nursing Directors. Elaine has been Director of Community Health for the Snohomish Health District since 1989, and adjunct faculty of School of Nursing, University of Washington since 1989. Her 25 years in health care have included clinical and public health nursing, instructor of nursing, and administration. Among her affiliations are previous Chair of the Public Health Nursing Directors of Washington, former member of the Executive Committee of Washington Association of Local Public Health Officials and Washington Core Public Health Function Committee, and a current member of the Capacity Standards Committee. Previously, Elaine served as president of the Arizona Public Health Association. She has been recognized for developing a Patient Acuity and Workload Analysis System for public health nursing. Elaine received a Master of Public Health from University of Washington, and a Bachelor of Science-Nursing from California State University.

Tim Douglas

Bellingham, representing the Association of Washington Cities. Tim was a three term mayor of Bellingham, completing his twelve years in that position in December, 1996. He has a long-standing involvement with public health. As a member of the Whatcom County Public Health Board, he helped end years of controversy by developing a formula for fair contributions from the County and its cities to fund public health services. Elected three times to the Board of the Association of Washington Cities, Tim served on an advisory committee on public health funding. He was an AWC member of the Tri-Association task group established by city and county associations to resolve public health funding issues. Tim has taken a leadership role in environmental issues. Governor Gardner appointed him to the Puget Sound Water Quality Authority to represent cities. He co-founded the Coalition for Clean Water, a statewide association of counties, cities, water and sewer districts which actively seeks good policy and necessary funding to improve water quality in the State. He served on the hazardous Waste Management Plan Advisory Committee, a group of business, government, citizen and non-governmental environmental groups which drafted a plan for managing hazardous wastes in the State. Tim now is a consultant in management and the environment. He is involved in a program of cooperative effort to improve marine water quality in the Russian Far East. He earned his M.S. in higher education administration at Indiana University in 1968, and a B.A. in Russian and Spanish from Washington State University in 1965.

William L. Dowling

Seattle, representing the University of Washington School of Public Health. Bill is a professor and chair of the Department of Health Services at the University of Washington. His teaching and research interests are in the areas of integrated delivery systems, health systems governance and management, strategic planning, health policy, and health care reform. He was previously vice president for planning and policy development for the Sisters of Providence Health System, which includes hospitals, long term care facilities, and managed care plans in Washington, Alaska, Oregon and California. He formerly taught at both the University of Washington, and the University of Michigan, and had administrative positions at several hospitals, including the University of Maryland Hospital, and the U.S. Naval Hospital in Oakland, California. He holds a Bachelor of Arts degree from Duke University, an M.B.A. in Hospital Administration from the University of Chicago, and an M.A. in economics and a Ph.D. in Medical Care Organization from the University of Michigan.

Phil Dyer

Issaquah, representing the Washington State House of Representatives. Phil is chair of the House Health Care Committee and a member of the Financial Institutions and Insurance Committee. He is a senior vice president of Washington Casualty Company and a retired major in the Washington Army National Guard. He has been active in several professional organizations, including the National Professional Liability Underwriting Society, the National

Society of Certified Insurance Counselors, the Washington Health Care Risk Management Society, and the Washington Institute for Policy Studies. He is also a member of the Kiwanis and other community organizations. He holds a Bachelor of Science degree from Oregon State University.

Jeanne A. Edwards

Bothell, representing Association of Washington Cities. Jeanne has served for five years on the Bothell City Council. She is in her second term as an elected member of Snohomish Health District's Board of Health. She is an active member of the Snohomish County Healthier Communities Steering Committee, the Everett Community Health Care Partnership and chairs the legislative committee of the King County Human Services Roundtable. Before leaving full-time employment, she was Executive Director of Community Health Centers of Snohomish County and worked as Assistant Administrator at General Hospital Medical Center in Everett, now Providence General Medical Center. As Administrator for marketing Jeanne worked on a team to create the Helen Jackson Center for Women's Health, the Stephen Saunders Health Care Center, and the Prenatal Care Center for low income women. She directed corporate relations which provided interface between business and various managed care insurance products. She is a consultant to the merged hospital. Jeanne was an editor and reporter for the Everett Herald assigned to national, state and local government coverage as well as general assignment reporting and editing.

Mimi L. Fields

Olympia, representing the Washington State Department of Health. Mimi is the State Health Officer/Deputy Secretary for the Department of Health. She has also served as Assistant Secretary for HIV/AIDS and Infectious Diseases, and as the first Director of the state Office on HIV/AIDS. As State Health Officer, Mimi is Lead physician for all public policy decisions on health and illness care in Washington. One of her primary responsibilities is development of local/state partnerships. Along with her roles for the Department of Health, Mimi is Assistant Dean for Public Health Practice at the University of Washington School of Public Health and Community Medicine. She also has experience teaching, lecturing and writing, and has had numerous academic appointments. She lectures frequently to professional and community groups, and has presented papers both nationally and internationally. Mimi received a Doctor of Medicine from University of Missouri, Columbia, a Master of Public Health from Harvard University, and a Bachelor of Arts and Bachelor of Science from Luther College. Mimi is board-certified in General Preventive Medicine and Public Health, and is board-eligible in Occupational Medicine and General Preventive Medicine.

Catherine M. Green

Vancouver, representing Washington area business. Cathy joined the Greater Vancouver Chamber of Commerce in 1987 as Director of Communications. She became Vice President in 1990, and was named President in 1995. As President of the Chamber, Cathy oversees the programs and services of the 1,100 member organization, including the implementation of the innovative, community-based Community Choices 2010, a project designed to improve the overall health of Clark County. Cathy holds a bachelor's degree in English from Whitman College and master's degrees in Journalism and Public Affairs from the University of Oregon.

Tom Hilyard

Tacoma, representing the Washington Health Care Policy Board. Tom is a member of the Health Care Policy Board which was created in July 1995. He also served two years on the Health Services Commission which preceded the Policy Board. Previously, Tom worked for Pierce County's Human Services Department for more than a decade, including six years as executive director. During that time, he also served as a health policy advisor to the Washington Basic Health Plan, served on Governor Booth Gardner's 1988 transition team and Governor Mike Lowry's 1992 transition team. Tom graduated from Western Washington University with a bachelor of arts degree in sociology and anthropology, and is a life-long resident of Pierce County. He was recognized as an Outstanding Young Man of America in 1983, and named in Who's Who Among Black Americans, 1980-1985.

Nancy Leer

Seattle, representing the Washington State Nurses Association. Nancy was appointed Executive Director of Washington State Nurses Association in 1995. Her background in health care operations and administration includes Executive Director of Planned Parenthood of Alameda and San Francisco counties, 12 years at Chinese Hospital in San Francisco, progressing from Director of Patient Care Services to Acting Hospital Administrator and CEO of the HMO. She was also Director of Staff Development and Director of Nursing at Marshal Hale Hospital, San Francisco.

She has consulted on Nursing Management. Nancy holds a Master of Public Administration in Health Services from the College of Notre Dame, California, and a Bachelor of Science in Nursing and Public Health, from the University of Ottawa.

Pat Libbey

Olympia, representing the Performance Measures/Capacity Standards TAC. Pat is the Director, Thurston County Public Health and Social Services Department in Olympia. In this position he manages this suburban/rural county public health department serving a population of 190,000. Previously he was the Assistant Director and Director of Social Services of this department and served as the Program Development Director of the Mason-Thurston County Action Council. In 1993 he received the Award for Excellence in Environmental Health from the National Association of County Health Officials and was Co-Recipient of the First Annual Jim Parker Memorial Award. He is Past President of the Washington State Association of Local Public Health Officials. He serves on the Board of Directors and Executive Committee of the National Association of County and City Health Officials. He was a scholar in the 3rd National Public Health Leadership Institute.

Ken Merry

Tacoma, representing Environmental Health. Ken is a manager with 31 years of comprehensive technical, managerial, and administrative experience in public health and municipal water supply in both local and state government. He is now the superintendent of the Tacoma Water Division, and was formerly the chief of the Office of Environmental Health Programs for the state of Washington Division of Health. He is a registered professional civil engineer in Washington and California, and is certified in Washington as a Water Distribution Manager IV. He is a member of the American Water Works Association and the American Water Resources Association. He has extensive experience in water supply regulation, program management and supervision, regional water utility planning, and media relations. He has a Master of Science degree in sanitary engineering, and a Bachelor of Science degree in civil engineering from Iowa State University.

Thomas L. Milne

Vancouver, representing the Washington State Association of Local Public Health Officials. Tom has served as Executive Director of Southwest Washington Health District since 1983, and serves on a number of regional committees and task forces addressing AIDS, access to medical care, substance abuse and other topics. He chairs the Washington State AIDSNET Council, is past president of Washington State Association of Local Public Health Officials, and serves on the Basic Health Plan Advisory Council. He is also on the Board of Directors of the National Association of City and County Health Officials. Tom is a member of the Editorial Advisory Board of Washington Health. He was a first year scholar in the National Public Health Leadership Institute. He holds a Bachelor of Science in Pharmacy from Oregon State University.

Bruce A. Miyahara

Seattle, representing the Washington State Department of Health. Bruce was appointed Secretary of the Department of Health in February, 1993 by Governor Lowry. He came from Seattle-King County Department of Health where he had served as Deputy Director and Chief Administrative Officer since 1986 and Acting Director in 1991. Previous posts included Director of Regional Health Services, Administrator of Jail Health Services, and Consultant for Primary Care Programs. In the early 1970s, Bruce worked with the group who started Seattle's free health clinics for the poor, which grew into the present community health center network. He has served as Treasurer of Washington State Public Health Association, Council Member of Pacific Medical Center, and is active in civic and community organizations. Bruce holds a Master of Health Administration, and a Bachelor of Arts from University of Washington.

Anita Monoian

Yakima, representing the Washington Association of Community and Migrant Health Clinics. Anita has served for 18 years as President and CEO of Yakima Neighborhood Health Services. Other activities include service on the Boards of Directors of Washington Association of Community Health Centers, National Association of Community Health Centers and Northwest Regional Primary Care Association of which she is past President. She is also on the Board and the Health Policy and HIV-AIDS Substance Abuse Committees of the National Association of Community Health Centers. She is a member of the Washington Rural Health Association. Also interested in environmental

health issues, Anita has served on the Washington State High Level Nuclear Waste Advisory Committee and the State Department of Ecology Solid Waste Advisory Committee.

Warren Featherstone Reid

Seattle, representing the State Board of Health. Feather is a self-employed attorney and consultant who is currently serving as chair of the State Board of Health. He was formerly senior counsel to the Senate Democratic Caucus of the Washington State Legislature, and served for four years as senior executive policy assistant in the Office of the Governor. He was for many years an assistant to U.S. Senator Warren G. Magnuson, with duties involving helping formulate positions on legislation and funding priorities in the fields of health, education, and social welfare. He is an Air Force veteran with service in the Korean War. He has Bachelor of Arts and Doctor of Law from the University of Washington.

Richard D. Rubin

Seattle, representing the Foundation for Health Care Quality. Rick is the President of the Foundation for Health Care Quality, a collaborative community organization, founded in 1988, and based in Seattle, Washington. The Foundation is dedicated to helping communities meet shared health information needs both locally and nationally. Nationally, the Foundation operated the Community Health Management Information System (CHMIS) Resource Center and the Quality Measurement Advisory Service. The resource center provides tools and materials to those purchasers and consumers to measure the quality of care in their local markets. In Washington state, the Foundation is working with public and private stakeholders on a variety of health information initiatives including; health information networks, value added content applications, outcome/performance measures and data privacy protections. During his 20 years in the health care and benefits business, Rick has served purchasers, providers, consumers and policy makers. In the recent past, Rick has served as President of EconoMedrics Inc., and acted as the Managing Director of the Employers' Health Purchasing Co-op. Rick is the publisher of the award winning Health Care Consumer Guide and also serves as a consultant on health policy issues. Rick sit on a variety of boards and is a frequent writer and speaker on health issues.

Ronald J. Schurra

Spokane, representing the Washington State Hospital Association. Before assuming his current position with Dominican Network/Holy Family Hospital in January of 1989, Ron served as the Executive Vice-President/Chief Operating Officer of St. Joseph's Mercy Hospital in Pontiac, Michigan, for 2 1/2 years. From 1984 to 1986, Ron served as Senior Vice-President and Chief Operating Officer for Venice Hospital in Venice, Florida. From 1975 to 1984, Ron worked as the Administrator of St. Francis Hospital in Escanaba, Michigan. From 1969 to 1975, Ron served as Assistant Director of Somerset Hospital in Somerset, New Jersey. Ron began his career in health care in 1968 as an assistant to the Health Care Commissioner in the State of New York. Ron received his bachelor's degree from St. Louis University in 1965 and his master's degree from the University of Michigan in 1969 and is currently a fellow in the American College of Health Care Executives.

Mary C. Selecky

Colville, representing the Finance and Governance Technical Advisory Committee. Mary is Administrator of the Northeast Tri County Health District, which includes Ferry, Pend Oreille and Stevens counties. She is the legislative chair and past President of the Washington State Association of Local Public Health Officials. From 1991-1992 she was a member of the access committee of the Washington Health Care Commission. Mary is on the Board of the National Association of City and County Health Officials. She has a Bachelor of Arts degree in history and political science from the University of Pennsylvania.

Mike Shelton

South Whidbey Island, representing the Washington State Association of Counties. Rick is an Island County Commissioner for District No. 1. Past general manager of Nichols Brothers Boat Builders, Inc. He has also worked in the banking industry in business development and credit administration, and in the construction industry with a focus on installation of on-site sewage disposal systems. He is the secretary/treasurer of the Washington Counties Risk Pool Executive Committee and serves on the Legislative Steering Committee of the Washington State Association of Counties. He has served on other organizations that focused on public transportation and airport siting. He has a Bachelor of Arts degree in Economics from Central Washington University.

John G. Thayer

Mount Vernon, representing the Washington State Environmental Health Directors. John has served as Director of Environmental Health for Skagit County Health Department since 1979. Prior posts with the department include Food Program Supervisor and General Sanitarian. He has served on the State Board of Health, and is a member of Washington State Public Health Association and Washington State Environmental Health Association, and has held several offices including Chair for Washington State Environmental Health Directors, and President of the Washington State Environmental Health Association. His activities in these organizations have included work related to food programs, farm worker housing issues, and legislation. John received a Bachelor of Science degree in Environmental Health from University of Washington.

Mel Tonasket

Nespelem, representing Indian health issues. Mel serves as Service Unit Director at the Colville Indian Health Center, Indian Health Service. His prior posts were Director of Indian Policy and Support Services for the State Department of Social and Health Services, and Public Affairs Specialist for the Indian Health Service, Portland office. His experience also includes 19 years on the Tribal Council of the Colville Confederated Tribes, the offices of President and first Vice President on the National Congress of American Indians, and two years on the American Indian Policy Review (Congressional) Commission. He is on the boards of Northwest Renewable Resources Center, United Indian of All Tribes Foundation, Governor's Indian Advisory Council and Paschal Sherman Indian School. Mel is an advisory board member to the Indian Education Program at Eastern Washington University, and the Graduate School of Public Administration and the Environmental Studies Program at University of Washington.

Terry W. Torgrenrud, M.D.

Tacoma, representing the Washington State Medical Association. Terry is Board certified Pediatrician with the University Place Pediatric Clinic. He is a Clinical professor of Pediatrics at the University of Washington, and a staff member at Tacoma General Hospital, Mary Bridge Children's Hospital, and St. Joseph's Hospital. Terry is currently on the Board of Directors for the Pierce County Medical Bureau, a member of the American Academy of Pediatrics and the Washington State Society of Pediatrics, and Chairman of the Citizens for Better Dental Health. He has a Bachelor of Science in Natural Science and in Medicine from the University of North Dakota; and his M.D. from the Bowman Gray, School of Medicine, Wake Forest University.

R. Lorraine Wojahn

Tacoma, representing the Washington State Senate. Lorraine is Senate President Pro Tempore, and vice chair of both the Health and Long Term Care, and Rules Committees. She sits on the Ways and Means, and Labor, Commerce and Trade Committees. She is a member of the Joint Committee on Legislative Audit and Review. She is actively involved in public health and community protection issues, especially in areas affecting women, children and consumers. At the state level she is a member of the Washington Council for Prevention of Child Abuse and Neglect, the Displaced Homemakers Advisory Committee, the Governor's Advisory Committee on HIV/AIDS, the Washington State Arts Commission, and the Public Health Improvement Plan Steering Committee. In her community she is a member of the Pierce County Commission Against Domestic Violence, a Board Member of the Eastside Boys' and Girls' Clubs of Tacoma, a member of Allenmore Hospital's Board of Directors, and she is a trustee of Consumer Credit Counseling Services, Inc., of Tacoma-Pierce County.

Department of Health Staff**Doreen D. Garcia**

Doreen is the director of Health Policy for the Department of Health, and coordinator of the *Public Health Improvement Plan* (PHIP). She managed the development of the first PHIP, which was submitted to the Legislature in December 1994, and supervises the Department of Health staff who are helping to implement that plan and have developed the 1996 Report. She is a member of the DOH executive management team. Previously she served as research director of the Washington Health Care Commission. She joined the Health Care Commission staff after working as a health policy analyst for the Prospective Payment Assessment Commission (ProPAC) in Washington, D.C. from 1987 through 1990. At ProPAC, she focused on health care financing issues, particularly pertaining to the federal Medicare program. From 1986 through 1987, she was a project analyst for Hospital Health Plan Corporation, a company that helped community hospitals form

their own health maintenance organizations. She earned a Masters of Public Policy degree from the John F. Kennedy School of Government at Harvard University, with an emphasis on health policy and long-term care. She earned a Bachelor of Arts degree in communication studies from the University of California at Los Angeles.

Stephen C. Kelso

Steve has been with the Office of Policy and Planning and its predecessor, the Office of Health Policy Support, since the Department of Health was created in 1989. He was the editor of *The Health of Washington State* and was the central editor for both the 1994 and 1996 Public Health Improvement Plans. Before that, he was involved in writing and producing several health assessment and policy development-related DOH publications, including *Tobacco and Health in Washington State* and the *Cancer Control Plan*. He developed a computer system to track health objectives and coordinated the production of comprehensive health data books provided to each local health jurisdiction as part of APEX/PH (Assessment Protocol for Excellence in Public Health). Before coming to DOH, he was a public information officer in the Department of Social and Health Services, and before that was a freelance writer of educational films. He attended Dartmouth College, the University of Washington, and San Francisco State College. He holds B.A. and M.A. degrees in creative writing.

Lucia A. Miltenberger

Lucia has been with the Department of Health, in the Office of Policy and Planning, since 1992. She worked with the Capacity Standards Technical Advisory Committee during the development of the 1994 *Public Health Improvement Plan*, and with the Performance Measures Technical Advisory Committee over the past two years. In addition, she has worked closely with Department of Health divisions to assist managers and staff in finding appropriate ways to integrate the concepts contained in the 1994 PHIP into program operations. She is participating in the review of the Consolidated Contract and will help modify it to comply with the legislative mandate to develop a performance based contract that focuses on improving both health status and core function performance. She was one of the coordinators for agency budget development and had major responsibility for drafting the strategic plan, goals and performance measures for the 1997-99 biennium. Prior to coming to the department she was a nursing home administrator with a national company. From 1978 to 1983 she was director of a community based volunteer organization which, in cooperation with local providers, developed a hospice program for Thurston County. She has a Master in Health Administration from the University of Washington and a Bachelor of Arts from the University of Portland.

Terry R. Reid

Since joining the state Department of Health in June 1994, Terry has worked as an analyst with the Office of Health Policy and Planning. He was lead staff to the Finance and Governance Technical Advisory Committee in 1995-96 and assisted in the development of the finance and governance and youth violence prevention sections of the 1994 PHIP report. He has assisted with the department's implementation of the Youth Violence Reduction Act through the contributing to the development of the "Community Network Planning Guideline Notebook" and the criteria for local health jurisdiction review of the community network plans. In addition, he has assisted in the department's development of the Public Health Partnerships. Previously, he spent nineteen years with the Tacoma-Pierce County Health Department, much of that time as a manager of the substance abuse and HIV/AIDS services. He was instrumental in the planning and development of many prevention and treatment programs, including needle exchange, that currently serve that community. As a member of the Safe Streets Prevention Partnership Steering Committee from 1991 through 1994, he helped link the local health department's services to community mobilization efforts. He received a Masters of Social Work in 1974 and a Bachelor of Science in Psychology in 1971 from the University of Washington. In 1972 he served as a VISTA volunteer in northern Idaho.

Marquita Schlender

Marquita has been with the Department of Health, in the Office of Health Policy and Planning since 1994. She serves as administrative support to the Policy staff, as well as the Public Health Improvement Plan Steering Committee. She has contributed to the production of the *Public Health Improvement Plan* as well as *The Health of Washington State*. She is a member of the Executive Support team for Department of Health. Prior to coming to Department of Health she worked in the business office for a local health clinic. She has an A.A. degree from Centralia College.

Appendix J. Technical Advisory Committee members and other contributors

Finance and Governance Technical Advisory Committee

Mary Selecky	Chair, Northeast Tri-County Health District
Fred Abrahamson	Department of Health - Office of Financial Services
Bobbie Berkowitz	University of Washington School of Public Health and Community Medicine
Joan Brewster	Department of Health - Planning
Oscar Cerda	Department of Health - Minority Affairs
Jan Dahl	Island County Health Department
Joe Finkbonner	Lummi Indian Business Council
Frank Hickey	Department of Health - Management Services
Sue Kelln	Spokane County Health District
Bob Kelly	City Manager, Kennewick
Ruth King	Office of Financial Management
Tom Locke	Clallam County Health and Human Services Department
Bruce Miyahara	Department of Health - Secretary
Rick Mockler	Snohomish Health District
Alonzo Plough	Seattle King County Department of Public Health
Mike Shelton	Commissioner, Island County
David Specter	Jefferson County Health and Human Services
Marilynn Sutherland	Cowlitz County Health Department
Kris VanGorkom	Department of Health - Legislative and Constituent Relations
Mike Vinatieri	Lewis County Public Services

Consultants

Kathleen Gerke	Association of Washington Cities
Bill Hagens	House Health Care Committee
Vicki Kirkpatrick	Washington State Association of Local Public Health Officials
Pat Libbey	Thurston County Health Department
Don Sloma	Senate Health and Long Term Care Committee
Mel Tonasket	Colville Indian Health Center
Jean Wessman	Washington State Association of Counties

Staff

Terry Reid	Department of Health - Health Policy
Rhonda Reinke	Department of Health - Fiscal Coordinator, Local Health Districts

Performance Measures Technical Advisory Committee

Pat Libbey, Chair	Thurston County Health Department
Bobbie Berkowitz	University of Washington School of Public Health and Community Medicine
Luann Carter	Tulalip Tribes
Elaine Conley	Snohomish Health District
Mimi Fields	Department of Health - State Health Officer
Jan Fleming	Department of Health - Community & Family Health
James Gale	Kittitas County Health Department
Gary Goldbaum	Seattle King County Department of Public Health
Bill Hagens	House Health Care Committee
Geoff Hughes	Department of Health - Community Environmental Health
Vicki Kirkpatrick	Washington State Association of Counties
Jim Krieger	Seattle King County Department of Public Health
Tom Locke	Clallam County Health and Human Services Department
Sherri McDonald	Thurston County Health Department
Tom Milne	Southwest Washington Health District
Tim Moody	Asotin County Health District
Carl Osaki	Seattle King County Department of Public Health
Mary Selecky	Northeast Tri-County Health District
Don Sloma	Senate Health and Long Term Care Committee
Paul Stehr-Green	Department of Health - State Epidemiologist
Jack Thompson	University of Washington - Health Policy Analysis Program
Mike Vinatieri	Lewis County Health Department

Staff

Lucia Miltenberger	Department of Health - Health Policy Office
John Nelson	Consultant

Appendix K. Other available PHIP-related reports

Available from Department of Health, Office of Health Policy, (360) 705-6032

The Health of Washington State, September 1996

Clinical Personal Health Services Technical Assistance Project Reports (Phase 1, May 1996 and Final, August 1996) (Includes Critical Question Checklist)

Use of Federal Public Health Funds in Washington State, August, 1995

Local Health Jurisdiction Fee Survey Report

Fee Tool Box for Local Health Jurisdictions, June 1996

Available from Department of Health, Office of Planning, (360) 664-2494

Directory of Washington State Local/Public Health Organizations, March 1996 (includes local health jurisdictions, tribes of Washington, universities, Washington State Board of Health, Washington State Department of Health)

Report on Local Capacity Development Funds

Available from Department of Health, Office of the Secretary, (360) 753-4736

Public Health Improvement Plan Education and Training Competency Model

Available from State Board of Health, (360) 586-0399

Biennial State Public Health Report

Available from the American Indian Health Commission, (360) 681-4604

Assessment of Core Public Health Capacities of Tribal Governments

Appendix L. PHIP Statutes

RCW 43.70.520 Public health services improvement plan

(1) The legislature finds that the public health functions of community assessment, policy development, and assurance of service delivery are essential elements in achieving the objectives of health reform in Washington state. The legislature further finds that the population-based services provided by state and local health departments are cost-effective and are a critical strategy for the long-term containment of health care costs. The legislature further finds that the public health system in the state lacks the capacity to fulfill these functions consistent with the needs of a reformed health care system.

(2) The department of health shall develop, in consultation with local health departments and districts, the state board of health, the health services commission, area Indian health service, and other state agencies, health services providers, and citizens concerned about public health, a public health services improvement plan. The plan shall provide a detailed accounting of deficits in the core functions of assessment, policy development, assurance of the current public health system, how additional public health funding would be used, and describe the benefits expected from expanded expenditures.

(3) The plan shall include:

(a) Definition of minimum standards for public health protection through assessment, policy development, and assurances:

(i) Enumeration of communities not meeting those standards;

(ii) A budget and staffing plan for bringing all communities up to minimum standards;

(iii) An analysis of the costs and benefits expected from adopting minimum public health standards for assessment, policy development, and assurances;

(b) Recommended strategies and a schedule for improving public health programs throughout the state, including:

(i) Strategies for transferring personal health care services from the public health system, into the uniform benefits package where feasible; and

(ii) Timing of increased funding for public health services linked to specific objectives for improving public health; and

(c) A recommended level of dedicated funding for public health services to be expressed in terms of a percentage of total health service expenditures in the state or a set per person amount; such recommendation shall also include methods to ensure that such funding does not supplant existing federal, state, and local funds received by local health departments, and methods of distributing funds among local health departments.

(4) The department shall coordinate this planning process with the study activities required in section 258, chapter 492, Laws of 1993.

(5) By March 1, 1994, the department shall provide initial recommendations of the public health services improvement plan to the legislature regarding minimum public health standards, and public health programs needed to address urgent needs, such as those cited in subsection (7) of this section.

(6) By December 1, 1994, the department shall present the public health services improvement plan to the legislature, with specific recommendations for each element of the plan to be implemented over the period from 1995 through 1997.

(7) Thereafter, the department shall update the public health services improvement plan for presentation to the legislature prior to the beginning of a new biennium.

(8) Among the specific population-based public health activities to be considered in the public health services improvement plan are: Health data assessment and chronic and infectious disease surveillance; rapid response to outbreaks of communicable disease; efforts to prevent and control specific communicable diseases, such as tuberculosis and acquired immune deficiency syndrome; health education to promote healthy behaviors and to reduce the prevalence of chronic disease, such as those linked to the

use of tobacco; access to primary care in coordination with existing community and migrant health clinics and other not for profit health care organizations; programs to ensure children are born as healthy as possible and they receive immunizations and adequate nutrition; efforts to prevent intentional and unintentional injury; programs to ensure the safety of drinking water and food supplies; poison control; trauma services; and other activities that have the potential to improve the health of the population or special populations and reduce the need for or cost of health services. [1993 c 492 § 467.]

CERTIFICATION OF ENROLLMENT

ENGROSSED SUBSTITUTE SENATE BILL 5253

Chapter 43, Laws of 1995
54th Legislature
1995 Regular Session

Public health improvement plan implementation

EFFECTIVE DATE: 7/1/95 - Except Sections 15 & 16 which become effective on 6/30/95; Sections 1 through 5, 12, & 13 which become effective 7/1/95; Section 9 which becomes effective on 4/17/95; and Sections 6 through 8, 10, & 11 which become effective on 1/1/96 or 1/1/98 (see section 17(4))

Passed by the Senate March 10, 1995
YEAS 45 NAYS 0

CERTIFICATE

I, Marty Brown, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE SENATE BILL 5253** as passed by the Senate and the House of Representatives on the dates hereon set forth.

JOEL PRITCHARD

President of the Senate

Passed by the House April 5, 1995
YEAS 92 NAYS 4

CLYDE BALLARD

**Speaker of the
House of Representatives**

MARTY BROWN

Secretary

Approved April 17, 1995

FILED

April 17, 1995 - 3:43 p.m.

MIKE LOWRY

Governor of the State of Washington

**Secretary of State
State of Washington**

ENGROSSED SUBSTITUTE SENATE BILL 5253

Passed Legislature - 1995 Regular Session

State of Washington

54th Legislature

1995 Regular Session

By Senate Committee on Health & Long-Term Care (originally sponsored by Senators Quigley, Moyer, Hargrove and C. Anderson; by request of Department of Health)

Read first time 02/09/95.

AN ACT Relating to implementation of the public health improvement plan; amending RCW 41.05.240, 70.05.030, 70.05.035, 70.05.050, 70.08.040, 70.46.020, 43.72.902, and 43.72.915; adding a new section to chapter 70.46 RCW; adding new sections to chapter 43.70 RCW; recodifying RCW 41.05.240; repealing 1993 c 492 s 244; repealing 1993 c 492 s 255; repealing 1993 c 492 s 256 (uncodified); providing effective dates; and declaring an emergency.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

The legislature declares its intent to implement the recommendations of the public health improvement plan by initiating a program to provide the public health system with the necessary capacity to improve the health outcomes of the population of Washington state and establishing the methodology by which improvement in the health outcomes and delivery of public health activities will be assessed.

Unless the context clearly requires otherwise, the definitions in this section apply throughout sections 1 through 3 of this act.

(1) "Capacity" means actions that public health jurisdictions must do as part of ongoing daily operations to adequately protect and promote health and prevent disease, injury, and premature death. The public health improvement plan identifies capacity necessary for assessment, policy development, administration, prevention, including promotion and protection, and access and quality.

(2) "Department" means the department of health.

(3) "Local health jurisdiction" means the local health agency, either county or multicounty, operated by local government, with oversight and direction from a local board of health, that provides public health services throughout a defined geographic area.

(4) "Health outcomes" means 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 in areas such as improving the rate of immunizations for infants and children to ninety percent and controlling and reducing the spread of tuberculosis and that are stated in the public health improvement plan.

(5) "Public health improvement plan," also known as the public health services improvement plan, means the public health services improvement plan established under RCW 43.70.520, developed by the department, in consultation with local health departments and districts, the state board of health, the health services commission, area Indian health services, and other state agencies, health services providers, and residents concerned about public health, to provide a detailed accounting of deficits in the core functions of assessment, policy development, and assurance of the current public health system, how additional public health funding would be used, and to describe the benefits expected from expanded expenditures.

(6) "Public health" means activities that society does collectively to assure the conditions in which people can be healthy. This includes organized community efforts to prevent, identify, preempt, and counter threats to the public's health.

(7) "Public health system" means the department, the state board of health, and local health jurisdictions.

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

(1) Identify, as part of the public health improvement plan, the key health outcomes sought for the population and the capacity needed by the public health system to fulfill its responsibilities in improving health outcomes.

(2)(a) Distribute state funds that, in conjunction with local revenues, are intended to improve the capacity of the public health system. The distribution methodology shall encourage system-wide effectiveness and efficiency and provide local health jurisdictions with the flexibility both to determine governance structures and address their unique needs.

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

(3) Develop criteria to assess the degree to which capacity is being achieved and ensure compliance by public health jurisdictions.

(4) Adopt rules necessary to carry out the purposes of chapter . . . , Laws of 1995 (this act).

(5) Biennially, within the public health improvement plan, evaluate the effectiveness of the public health system, assess the degree to which the public health system is attaining the capacity to improve the status of the public's health, and report progress made by each local health jurisdiction toward improving health outcomes.

RCW 41.05.240 and 1993 c 492 s 468 are each amended to read as follows:

Consistent with funds appropriated specifically for this purpose, the ~~((authority))~~ department shall establish in conjunction with the area Indian health services system and providers an advisory group comprised of Indian and non-Indian health care facilities and providers to formulate an American Indian health care delivery plan. The plan shall include:

(1) Recommendations to providers and facilities methods for coordinating and joint venturing with the Indian health services for service delivery;

(2) Methods to improve American Indian-specific health programming; and

(3) Creation of co-funding recommendations and opportunities for the unmet health services programming needs of American Indians.

RCW 41.05.240 shall be recodified as a new section in chapter 43.70 RCW.

RCW 70.05.030 and 1993 c 492 s 235 are each amended to read as follows:

In counties without a home rule charter, the board of county commissioners shall constitute the local board of health, unless the county is part of a health district pursuant to chapter 70.46 RCW. The jurisdiction of the local board of health shall be

coextensive with the boundaries of said county. The board of county commissioners may, at its discretion, adopt an ordinance expanding the size and composition of the board of health to include elected officials from cities and towns and persons other than elected officials as members so long as persons other than elected officials do not constitute a majority. An ordinance adopted under this section shall include provisions for the appointment, term, and compensation, or reimbursement of expenses.

RCW 70.05.035 and 1993 c 492 s 237 are each amended to read as follows:

In counties with a home rule charter, the county legislative authority shall establish a local board of health and may prescribe the membership and selection process for the board. The county legislative authority may appoint to the board of health elected officials from cities and towns and persons other than elected officials as members so long as persons other than elected officials do not constitute a majority. The county legislative authority shall specify the appointment, term, and compensation or reimbursement of expenses. The jurisdiction of the local board of health shall be coextensive with the boundaries of the county. The local health officer, as described in RCW 70.05.050, shall be appointed by the official designated under the provisions of the county charter. The same official designated under the provisions of the county charter may appoint an administrative officer, as described in RCW 70.05.045.

RCW 70.05.050 and 1993 c 492 s 238 are each amended to read as follows:

The local health officer shall be an experienced physician licensed to practice medicine and surgery or osteopathy and surgery in this state and who is qualified or provisionally qualified in accordance with the standards prescribed in RCW 70.05.051 through 70.05.055 to hold the office of local health officer. No term of office shall be established for the local health officer but the local health officer shall not be removed until after notice is given, and an opportunity for a hearing before the board or official responsible for his or her appointment under this section as to the reason for his or her removal. The local health officer shall act as executive secretary to, and administrative officer for the local board of health and shall also be empowered to employ such technical and other personnel as approved by the local board of health except where the local board of health has appointed an administrative officer under RCW 70.05.040. The local health officer shall be paid such salary and allowed such expenses as shall be determined by the local board of health. In home rule counties that are part of a health district under this chapter and chapter 70.46 RCW the local health officer and administrative officer shall be appointed by the local board of health.

RCW 70.08.040 and 1985 c 124 s 4 are each amended to read as follows:

Notwithstanding any provisions to the contrary contained in any city or county charter, where a combined department is established under this chapter, the director of public health under this chapter shall be appointed by the county executive of the county and the mayor of the city (~~for a term of four years and until a successor is appointed and confirmed. The director of public health may be reappointed by the county executive of the county and the mayor of the city for additional four year terms~~). The appointment shall be effective only upon a majority vote confirmation of the legislative authority of the county and the legislative authority of the city. The director may be removed by the county executive of the county, after consultation with the mayor of the city, upon filing a statement of reasons therefor with the legislative authorities of the county and the city.

RCW 70.46.020 and 1993 c 492 s 247 are each amended to read as follows:

Health districts consisting of two or more counties may be created whenever two or more boards of county commissioners shall by resolution establish a district for such purpose. Such a district shall consist of all the area of the combined counties. The district board of health of such a district shall consist of not less than five members for districts of two counties and seven members for districts of more than two counties, including two representatives from each county who are members of the board of county commissioners and who are appointed by the board of county commissioners of each county within the district, and shall have a jurisdiction coextensive with the combined boundaries. The boards of county commissioners may by resolution or ordinance provide for elected officials from cities and towns and persons other than elected officials as members of the district board of health so long as persons other than elected officials do not constitute a majority. A resolution or ordinance adopted under this section must specify the provisions for the appointment, term, and compensation, or reimbursement of expenses. Any multicounty

health district existing on the effective date of this act shall continue in existence unless and until changed by affirmative action of all boards of county commissioners or one or more counties withdraws pursuant to RCW 70.46.090.

At the first meeting of a district board of health the members shall elect a chair to serve for a period of one year.

A new section is added to chapter 70.46 RCW to read as follows:

A health district to consist of one county may be created whenever the county legislative authority of the county shall pass a resolution or ordinance to organize such a health district under chapter 70.05 RCW and this chapter.

The resolution or ordinance may specify the membership, representation on the district health board, or other matters relative to the formation or operation of the health district. The county legislative authority may appoint elected officials from cities and towns and persons other than elected officials as members of the health district board so long as persons other than elected officials do not constitute a majority.

Any single county health district existing on the effective date of this act shall continue in existence unless and until changed by affirmative action of the county legislative authority.

RCW 43.72.902 and 1993 c 492 s 470 are each amended to read as follows:

The public health services account is created in the state treasury. Moneys in the account may be spent only after appropriation. Moneys in the account may be expended only for maintaining and improving the health of Washington residents through the public health system. For purposes of this section, the public health system shall consist of the state board of health, the state department of health, and local health departments and districts. ~~((Funds appropriated from this account to local health departments and districts shall be distributed ratably based on county population as last determined by the office of financial management.))~~

Sections 1 through 3 of this act are each added to chapter 43.70 RCW.

If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

RCW 43.72.915 and 1993 sp.s. c 25 s 603 are each amended to read as follows:

This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect July 1, 1993, except for:

(1) Sections 234 through 243, 245 through 254, and 257 of this act, which shall take effect ~~((July 1, 1995))~~ January 1, 1996 or January 1, 1998, if funding is not provided as set forth in section 17(4) of this act; and

(2) Sections 301 through 303 of this act, which shall take effect January 1, 1994.

The following acts or parts of acts are each repealed, effective June 30, 1995:

(1) 1993 c 492 s 244;

(2) 1993 c 492 s 256 (uncodified); and

(3) 1993 c 492 s 255.

1 **NEW SECTION. Sec. 2.** (1) Sections 15 and 16 of this act are necessary for the immediate preservation of the public peace,
2 health, or safety, or support of the state government and its existing public institutions, and shall take effect June 30, 1995.

3 (2) Sections 1 through 5, 12, and 13 of this act are necessary for the immediate preservation of the public peace, health, or
4 safety, or support of the state government and its existing public institutions, and shall take effect July 1, 1995.

5 (3) Section 9 of this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the
6 state government and its existing public institutions, and shall take effect immediately.

7 (4) Sections 6 through 8, 10, and 11 of this act take effect January 1, 1996, if funding of at least two million two hundred fifty
8 thousand dollars, is provided by June 30, 1995, in the 1995 omnibus appropriations act or as a result of the passage of Senate Bill

1 No. 6058, to implement the changes in public health governance as outlined in this act. If such funding is not provided, sections 6
2 through 8, 10, and 11 of this act shall take effect January 1, 1998.

Passed the Senate March 10, 1995.

Passed the House April 5, 1995.

Approved by the Governor April 17, 1995.

Filed in Office of Secretary of State April 17, 1995.

Appendix M: Clinical Services Decision-Making Critical Questions Checklist

Purpose of the Checklist

After the first year of site visits, the Clinical Personal Health Services Technical Assistance Project team from HPAP and WSALPHO and its steering committee consulted about how to best use the information gained through the visits to assist all local public health jurisdictions. The concept of a self-administered checklist to help guide the local health jurisdictions through a structured decision process was pursued as an outcome of these deliberations. The checklist would become one of the lasting technical assistance contributions of the project for the local health jurisdictions in Washington state. The original concept was to focus on three areas: (1) basic areas and categories to be considered; (2) information sources for the analysis; and (3) resources nationally and in other local public health jurisdictions and at the state level that an local health jurisdiction might consider using in its decision-making process.

The checklist was developed with the idea that it could be completed by local health jurisdiction management teams in a relatively short time. The process, which allows the local health jurisdiction to comment on its current progress in the area, can serve as a summary of what has been accomplished to date and the areas that need attention. Such analysis can then form the basis for more detailed work by the local health jurisdiction, including use of the more comprehensive checklist developed by the U.S. Department of Health and Human Services (DHHS), Agency for Health Care Policy and Research (AHCPR) (Bartlett, et al., nd). This process was envisioned as a part of a broader community process to determine future directions for service development.

Early "field-tests" of the concept with sites involved in the project led to the development of the most important addition to the checklist: the development of "critical questions" which must be asked by and of the jurisdiction as decisions about clinical services provision are being developed. The concept was that if the critical questions are answered, the specifics of the process through which the checklist is used could then be followed in the manner most comfortable for the local health jurisdiction. In other words, the questions which must be asked of local public health are the same statewide, but the ways in which the questions are answered might differ significantly from one jurisdiction to another. The questions address the basic information required for decision making. They were developed by the sites, the project team, and the steering committee over a period of several months. The resulting Critical Questions Checklist is described below.

Areas for Assessment

The Critical Questions Checklist directs local public health jurisdictions to consider four major evaluation areas: (1) the current role of the local health jurisdiction including scope of services, affiliations with plans for clinical services, and other partnerships; (2) community information demographic and epidemiologic information and evidence of consumer perceptions about health status; (3) community capacity and insurance status of residents including market penetration by health plans, services to special populations (as defined by the community), and the number of uninsured in the community; and (4) the preferred future role of the local health jurisdiction including community processes for determining health priorities, the preferred role of the system

and of the local health jurisdiction, and resulting clinical and population-based services and partnerships.

Considerations Within Each Area

Each of the four evaluation areas is broken down into categories for analysis, with research questions posed for each category. The categories of analysis within each evaluation area and the critical questions that must be answered by local health jurisdictions to help assess their role in clinical services are identified in the first of four columns across the checklist page. Exhibit A, below, illustrates a typical page of the checklist for the purposes of the exhibit, only the first column has information entered into it.

Clinical Services Provision Decision-Making Critical Questions Checklist

EVALUATION AREA II: Community Information

CATEGORY	INFORMATION SOURCES What to look at for answers.	STATUS Do you have these sources? Where?	OTHER RESOURCES Where to find further information.	✓
1) Demographic Information (define a base set) Who live in this community?	- [source] - [source] - [source]		- [resource] - [resource] - [resource]	
2) Selected Health Status Indicators (define a base set) What is the health status of community residents? Which health status indicators should you select for review and why?	- [source] - [source] - [source]		- [resource] - [resource] - [resource]	

The information sources that will help answer the critical questions are identified in the second column. The third column provides a space for the local health jurisdiction to enter the status of these sources (for example, whether they are readily available, where to get them, or whether the local health jurisdiction wants to use them), thereby helping to confirm that there is sufficient information to successfully respond to the critical questions. The final column identifies other resources many of which were identified for Washington in the first year of the project that the local health jurisdiction can turn to for further assistance within a particular area and category if there is not sufficient information to date.

As an example, the evaluation area "Community Information" in the Critical Questions Checklist will help a local health department develop a profile of the community it serves. The first two things the local health jurisdiction might want to think about in developing such a profile indicated as categories in the checklist are demographic and health status information. Several information sources, such as the results of a community assessment, census data, or other specific data collections, might be available to the local health jurisdiction that will help it understand the make-up of its community. The local health jurisdiction would review the list of

these information sources in the second column of the checklist for their applicability and availability, and perhaps add others to the end of the list. The local health jurisdiction then would enter the status of the information sources in the third column of the checklist.

The local health jurisdiction might want assistance with developing its community profile it might be helpful, for example, to talk to other local health jurisdictions about how they conducted such a process. The fourth column of the checklist identifies such other resources that are available to the local health jurisdiction, and provides a line to check off the ones the local health jurisdiction might want to use. If, for example, the local health jurisdiction believes that a community assessment would be a logical first step in the process of determining the level of clinical services it ought to provide in the future, but it has never conducted one, it can refer to other resources in the fourth column for the names of other local health jurisdictions that have.

Testing of the Checklist

The draft checklist was field-tested with the management team in the Kittitas County Health Department and the Snohomish Health District. The perspectives of these two local public health jurisdictions were very valuable in its further refinement. The Kittitas County staff spoke of the importance of the critical questions in the problem-solving in which they were engaged about continuation of clinical services and the financial implications of either continuation or transition. The Snohomish Health District reminded the team that a major driver in deliberations about clinical services was the extent to which the focus was on primary care vs. clinical preventive services. A decision to provide the former entailed a very different set of relationships with community providers than the latter. These site visits yielded useful information both about the elements to include in the checklist and about its organization and utility at the local level. The checklist was reorganized to reflect much of this feedback, including beginning the evaluation process with an analysis of the local jurisdiction's current activities and then moving on to community information, community capacity, and insurance information.

Relationship to DHHS/AHCPR Workbook for Local Health Officers

As the checklist instrument was being developed, project staff learned of a project undertaken by Health Systems Research, Inc., under contract with the Agency for Health Care Policy and Research (DHHS) to develop a workbook for local health officials titled *Assessing Roles, Responsibilities, and Activities in a Managed Care Environment*. According to the workbook introduction, the purpose of the document is to "assist (local health) officials in examining...changes (in the health system) and in charting a logical and appropriate future course for their individual local health departments."

This workbook is much more comprehensive than the checklist envisioned in this project, but is very complementary. This work does an excellent job of covering in detail both the community aspects of working in a managed care environment including such areas as "managed care-related community assessment issues," and "opportunities for carrying out core public health functions in a managed care environment" and areas more applicable to local health jurisdictions involved in primary care with sections such as "utilization and financial analysis of local health jurisdictions provided personal health care and related services" and "assessing alternative arrangements for providing personal health care and related services in a managed care environment." In conversation with Health Systems Research staff, it was agreed that the checklist approach used in for this project could serve as the introduction for the more extensive examination envisioned in the workbook.

*** ORDER FORM ***

1996 Public Health Improvement Plan

or

The Health of Washington State

NAME: _____

MAILING ADDRESS: _____

PHONE NUMBER: () _____

Please send me the following:

<i># of Copies</i>	<i>Title</i>	<i>Total</i>
_____	<i>1996 Public Health Improvement Plan @ \$6.00 ea. (available December 1996)</i>	_____
_____	<i>The Health of Washington State @ \$11.00 ea.</i>	_____
	<i>Washington residents add tax at 8.0%</i>	_____
	<i>Total Amount Enclosed</i>	<i>\$</i> _____

Return this order form with your check or money order payable to:
Department of Health
PO Box 1099
Olympia, WA 98507-1099

Name: _____

