



2006

Public Health Improvement Plan

Creating a Healthier Washington – Improving Public Health

A VISION FOR WASHINGTON'S PUBLIC HEALTH SYSTEM

Washington State's public health partners envision a public health system that promotes good health and provides improved protection from disease, injury, and hazards in the environment.

To help realize that goal, the public health system is committed to:

- Focusing our resources effectively, defining and monitoring outcomes for key public health issues and trends, and emphasizing evidence-based strategies;
- Maintaining a results-based accountability system, with meaningful performance measures and program evaluation;
- Using standardized technology across the public health system;
- Maintaining a workforce that is well-trained for current public health challenges and has access to continuous professional development;
- Facilitating discussions about health care access and delivery issues from the perspective of community systems, where the experiences of patients, providers, purchasers, and payers are important components;
- Applying communications strategies that are effective and foster greater public involvement in achieving public health goals; and
- Establishing new coalitions and alliances—among stakeholders, policy makers, and leaders—that support the mission of public health.



The 2006 Public Health Improvement Plan summarizes the works of many people who have joined efforts in committees and work groups. More detailed, full reports are available.

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

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PHIP 2006:

CREATING A HEALTHIER WASHINGTON
—IMPROVING PUBLIC HEALTH

December 2006



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Washington State Board of Health
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December 2006

Dear Friends of Public Health:

It is with pride and gratitude that I share the 2006 Public Health Improvement Plan: *Creating a Healthier Washington—Improving Public Health*.

This product is the result of collaboration by local public health officials, state public health workers, and our partners at the University of Washington, the state Board of Health, and the Washington Health Foundation. During 2006, the American Indian Health Commission and Washington State Public Health Association were also invited to join our partnership. Thank you to everyone who participates, for your time, ideas, expertise and creative approach to challenges.

Our partnership provides a way for people in diverse communities to pursue a common goal of protecting the public's health. Through ongoing work to implement and build upon previous plans, public health leaders of Washington are strengthening our public health system. Their collaboration has become a model for other states and other sectors of government.

A strong public health system is a vital part of creating a safer and healthier Washington. I am proud to be part of a public health community that is innovative and forward looking.

Sincerely,

A handwritten signature in cursive script that reads "Mary C. Selecky".

Mary C. Selecky
Secretary of Health

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SUMMARY: PUBLIC HEALTH IMPROVEMENT PLAN RECOMMENDATIONS

Washington's public health system is a statewide network that provides essential programs for improving health and is a trusted source for health information. From assuring safe food and water to halting epidemics, Washington's 5,400 public health workers provide services that protect us all—every day.

However, the state's public health system is challenged to maintain public health protection in the face of ever increasing demand for services and severely strained resources.

To respond to these challenges and implement the Public Health Improvement Plan (PHIP) laws (RCW 43.70.520, and .580), an innovative PHIP partnership has been created. The partnership includes about 200 local and state public health officials and representatives of organizations dedicated to improving public health. Working as a board of directors and in seven standing committees, they implement the objectives set forth in a two-year work plan.

The 2006 Public Health Improvement Plan describes challenges facing public health and makes recommendations for the future. In addition, the plan describes the work of PHIP committees and outlines planned next steps to improve Washington's public health system.

CHALLENGES FACING PUBLIC HEALTH

Increasing Demand

Public health needs are increasing. Some examples:

- Global travel and trade means diseases such as Severe Acute Respiratory Syndrome (SARS) or pandemic flu can spread rapidly from other parts of the world.
- Animal-borne diseases are increasing: E.coli, avian flu, West Nile virus.
- Our childhood immunization rates are below the national average.
- Tobacco use continues to result in early deaths. Lack of physical activity, combined with poor nutrition, has brought an epidemic of obesity. Diabetes is increasing among children and adults.

Decreasing Resources

The public health system is under severe strain. Overall, funding is about half of what public health officials estimate is needed to prevent disease and promote health throughout the state.

- Lack of dedicated funding makes the system unstable from one year to the next. Categorical funding carries restrictions that often do not match local needs.
- Adjusted for inflation, local tax funding for local public health has decreased. State funding declined by about 25% between 1998 and 2004 (adjusting for inflation and two special use funds).

PHIP—AN INNOVATIVE PARTNERSHIP

Despite increased demands and strained resources, Washington’s public health leaders have created a strong and innovative partnership, addressing public health challenges by working as a coordinated system. The PHIP directors, implementing RCW 43.70.520 and .580, have:

- Developed performance standards and measured the capacity of the public health system to carry out basic functions,
- Estimated the costs of filling gaps in public health services statewide,
- Created a list of key health indicators to measure health outcomes at the local level, and
- Implemented workforce training and technology coordination efforts to improve the effectiveness of services.

For more information, see: www.doh.wa.gov/phip

Figure ii

PHIP RECOMMENDATIONS

The PHIP partnership recommends that the following steps be taken by state and local policy makers to assure Washington residents are served by a strong and reliable public health system in the years to come:

1. Finance public health so that funding is stable and sufficient in all jurisdictions

To achieve health outcome goals, as envisioned in the PHIP laws, resources must be dedicated to health protection and prevention efforts—and sustained over time.

Today, funding is piecemeal. There is no dedicated funding to support public health, and the local funding base has not kept pace with growth and inflation. Funding levels vary dramatically from one community to the next, and restrictions attached to categorical grants leave little flexibility to respond to emerging community needs. Overall, funding at the local level is estimated to be about half of what is needed.

2. Assure that health officials have the information they need to make decisions that protect and improve the health of people

To protect people, public health officials must be able to rely on robust information systems to monitor disease trends, environmental risks, and health threats.

Information resources carry a cost, require expertise, and must be maintained. Today, variation in funding levels and over-reliance on one-time grants puts information resources in jeopardy.

3. Expand performance management to include a public health services inventory

Analysis of the capacity of the public health system to carry out basic functions has been completed with the process that was used to measure the public health standards.

In addition, local public health indicators have been developed and will be used to monitor progress toward improved health in the future.

Next, a public health services inventory should be designed and completed. It should document both the type and amount of services provided in each jurisdiction, contributing to the information base needed to effectively manage performance in public health. Today, there is reporting on state and local grant programs, but it is fragmented. No common reporting of local public health services is available.

4. Strengthen the public health system and delivery of public health services in all communities

The 2005 standards results (described in Chapter 2) recommend improvements to the public health system: consistent evaluation of program results, standardized templates and information systems, adoption of quality improvement tools, and readily accessible training. These improvements should be implemented to make the public health system effective and efficient.



NEXT STEPS FOR PHIP COMMITTEES

Washington's public health leaders work to implement a vision for an improved public health system in Washington. During the coming months, the PHIP directors recommend the following objectives be pursued by PHIP committees:

PHIP Board of Directors

1. By mid-2007, adopt a workplan and budget to support needed

actions to implement the findings of PHIP-supported studies.

2. Complete and publish the 2008 Public Health Improvement Plan

Key Health Indicators

1. By mid-2007, make county-level data available online for the local public health indicators. Monitor indicators and update data at least every other year. Incorporate indicators with the results of performance assessment in 2008.
2. By 2008, develop a funding strategy for ongoing support of local health data collection, including the Behavioral Risk Factor Surveillance System and the Healthy Youth Survey.
3. By 2008, develop a plan to sustain and enhance staff resources and technology tools to support the ongoing monitoring of health trends at the community level.

Performance Management

1. In 2007-08, provide communications materials and carry out training on the revised Standards for Public Health so they are familiar to all public health workers.
2. By 2008, provide a self-assessment guide to state and local programs so they can begin documentation well in advance of the next performance review.
3. In 2008-09, provide training and technical assistance based on the results of the 2008 performance measurement cycle with a special emphasis on the high priority area of *establishing clear program goals and objectives and the use of performance measures.*

Workforce Development

1. By mid-2007, provide final public health orientation materials online; periodically inform workers about their availability. Develop a plan to address updating and evaluation of materials.
2. By early 2008, complete training of public health workers in performance measurement in preparation for the 2008 performance measurement cycle.
3. By 2008, assess and prioritize learning needs within the public health workforce. Identify and publicize learning resources online and through other venues.

Information Technology

1. By 2009, develop a plan and implementation timeline for a coordinating board for public health technology, engaging potential users and exploring options for mission, structure, and process.
2. In 2008, provide information technology training to local public health agencies.
3. In 2008-09, provide training to public health workers in Business Process Analysis and apply this method in selecting software for common use.

Communications

1. In 2008, update Washington's public health communications messages in response to changes in public knowledge and attitudes toward public health.
2. In 2008-09, provide training to public health workers to harness the potential of Washington's public health workforce as every-day spokespeople for the value of public health to individuals, families, and communities.
3. In 2008-09, improve communications to the business sector to demonstrate the link between healthy communities and a healthy business climate.

PHIP 2006:

CREATING A HEALTHIER WASHINGTON
—IMPROVING PUBLIC HEALTH



INTRODUCTION

Everyday, everyone in Washington benefits from the science and services of public health. A few examples are shown in Figure 1.

The 2006 Public Health Improvement Plan describes the impact of public health in our daily lives and implications for creating a healthier future. It describes the innovative steps Washington's public health officials are taking to strengthen our public health system and outlines challenges that must be addressed in order to preserve

the advances we have made—and to provide for the healthiest possible future.



WHAT IS PUBLIC HEALTH?

Public health refers to actions society takes to protect the community as a whole. It encompasses policies, education, and programs that affect many people at once. Such actions are called “population-based” because they are designed to benefit the whole population and are usually actions individuals cannot take on their own.

EVERYDAY IN WASHINGTON STATE

- The state Department of Health, 35 local health jurisdictions, 95 licensed hospitals, and many other partners work together to ensure our communities are prepared for public health emergencies.
- About 210 babies are born, and our Newborn Screening Lab helps them get a healthy start through early detection and prompt care of treatable diseases.
- More than 5 million people have safe, reliable drinking water because of state and local drinking water programs and the local inspection of septic tank plans and installations.
- More than 160,000 women and young children receive healthy food from the WIC program in local communities.
- 35 people call the statewide Tobacco Quit Line and take the first step toward quitting smoking.
- Over 2.5 million residents eat in restaurants with confidence thanks to the efforts of local health departments and our Food Safety program staff.
- About 95 percent of kids entering school are protected against preventable diseases because of the immunization efforts of local and state programs.
- More than 400 samples are collected locally and tested by the state Public Health Laboratories for diseases like West Nile virus and influenza.

Source: Washington State Department of Health

Figure 1

Our generally good quality of life rests on public health measures taken by our predecessors. They built safe drinking water supplies, created systems to remove garbage, made vaccines available, provided information about hand washing and safe food handling, held vaccine campaigns, and passed laws that helped protect us all, such as prohibiting drinking and driving.

Today, public health is protected and promoted by a network of 35 local government health departments and districts, along with the state Department of Health, and other state agencies, including the state Board of Health.

While many partners compose the public health system (see Figure 2), the attention of the PHIP is on the *governmental* parts of the system, where formal authority and responsibility lay for protecting people's health at the population level. In this way, the role of public health agencies is similar to other public

safety agencies, such as fire and police departments.



WHAT IS THE PHIP?

In 1993, the Washington State legislature included public health as a key component of health reform laws, citing public health as a critical component to improve health and contain health care costs. The legislation required a Public Health Improvement Plan to be created. In 1995, the legislature accepted the first plan and extended the requirement so that there would be an ongoing effort to strengthen the state's public health system. (See Appendix 1, PHIP Laws)

Washington's PHIP has evolved based on strong partnerships and has become a model for many other states. For each plan, public health partners work in committees to implement strategies based on a clear vision of a public health system that provides core government services that people can rely on. (See inside cover, Vision Statement)

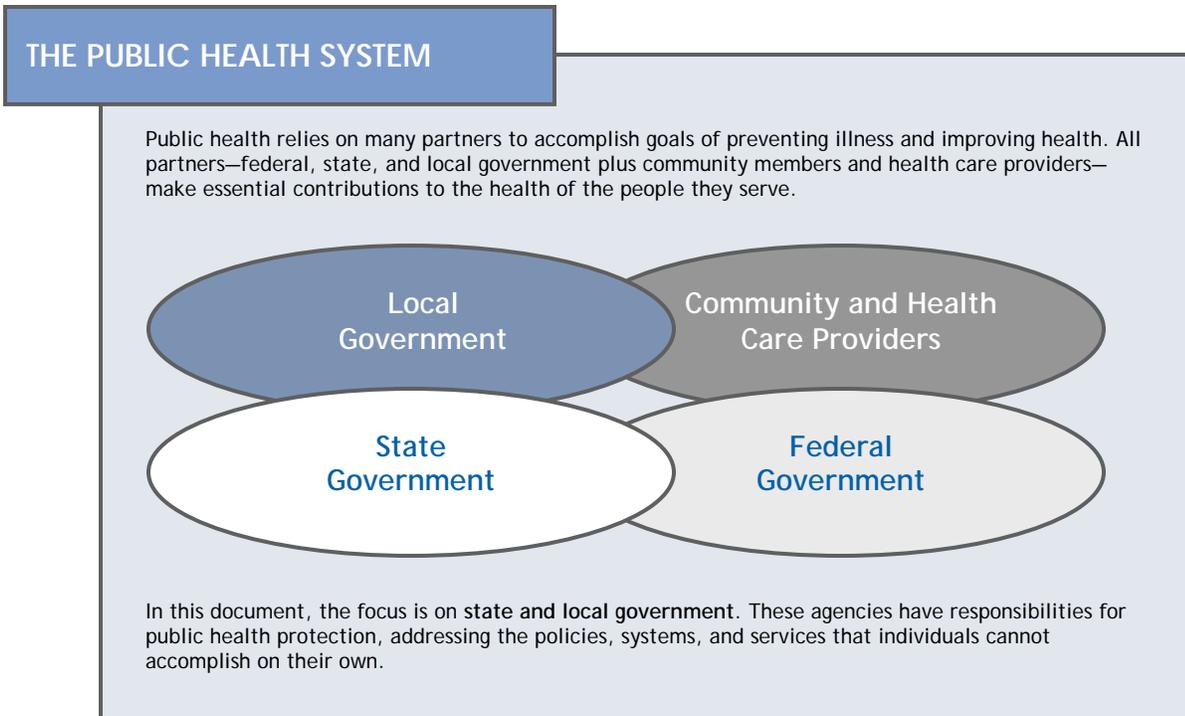


Figure 2

Today, the Public Health Improvement Partnership is best described as public health experts working together collaboratively to improve the quality and availability of public health services throughout Washington. Strong partnership has become a way of doing business, with the active involvement of public health leaders extending beyond the written plan.

The PHIP partners include:

- Washington State Department of Health
- Washington State Association of Local Public Health Officials
- Washington State Board of Health
- Northwest Center for Public Health Practice, University of Washington School of Public Health and Community Medicine
- Washington Health Foundation
- American Indian Health Commission for Washington State
- Washington State Public Health Association



WHAT IS IN THE 2006 PHIP REPORT?

Chapter 1 describes the determinants of health, explaining how our

health depends on underlying factors which encompass much more than health insurance or medical care and provides information about the health of the people of Washington.

Chapter 2 outlines the opportunities for greater health, better quality lives, and lower health care costs. These can be attained through systematic public health efforts that remove or mitigate the factors that cause illness, environmental health problems, and premature death.

Chapter 3 details the PHIP activities designed to strengthen Washington's public health system and to improve public health services statewide.

The *Summary of Recommendations*, placed on pages vii to x of this report are based on the work of all PHIP committees. In addition to four general recommendations, each committee has fulfilled a specific workplan and set the course for the future by outlining next steps.

Details about the PHIP committees, workplans, and accomplishments can be seen at www.doh.wa.gov/hip.



CHAPTER 1: HOW HEALTHY ARE WE? Measuring Our Health

CHANGING PERSPECTIVES: THE LEADING CAUSES OF DEATH

Asked about the leading causes of death, most people would answer heart disease, cancer, or stroke. While these conditions are the most numerous entries on death certificates, public health leaders point out that it is far more important to look at the real—or underlying—causes of death. This view reveals the immense toll taken on our society by premature death. In other words, deaths that could be prevented in exchange for years of healthy life.

In 1993, J. Michael McGinnis, MD, MPP, and William F. Foege, MD, MPH, both prominent leaders in public health, undertook a project

to calculate the high costs of public health problems either resulting in early death or in long-term disease and disability. Their explanation of the real causes of death is shown in Figure 3. This perspective is often referred to as the “health determinants” view because it includes factors, such as behavior and environment, which determine our level of health.

The McGinnis and Foege work also sheds light on the imbalance of investment in medical care compared to prevention activities. Figure 4, next page, shows the relative importance of different health determinants and illustrates how only a small proportion of overall health spending is dedicated to addressing health determinants.

CAUSES OF DEATH: THE PREVENTION PERSPECTIVE

Leading Causes of Death

- Heart disease
- Cancer
- Stroke
- Injury
- Chronic lung disease
- Pneumonia/flu
- Diabetes
- Suicide
- Liver disease
- HIV infection

Real Causes of Death

- Tobacco use
- Improper diet
- Lack of physical activity
- Alcohol misuse
- Microbial/toxic agents
- Firearm misuse
- Unsafe sexual behavior
- Motor vehicle crashes
- Use of illicit drugs

Source: McGinnis, M. and Foege, W., Actual Causes of Death in the United States, *Journal of the American Medical Association*. 1993; 270:2207-11.

Figure 3

FACTORS THAT INFLUENCE HEALTH STATUS AND HEALTH SPENDING

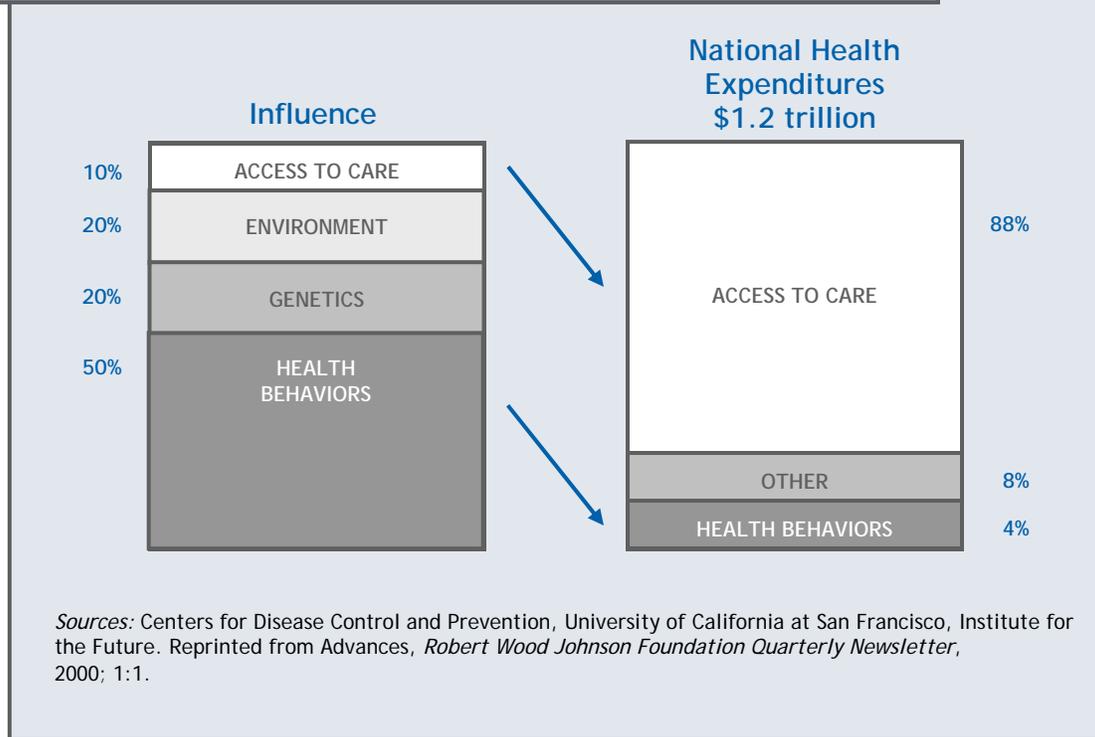


Figure 4

Public health leaders believe that by shifting our focus to prevention, many lives could be saved or improved, and the cost of health care could be reduced. With this shift in focus, our definition of health is not just the absence of disease, but encompasses our overall well being and quality of life.

MEASURING OUR HEALTH

Answering the question “How healthy are we?” must begin with a way to measure health. In Washington, we chose to use the health-determinants approach to look at national, state, and county data to examine our overall level of health.

Measuring health is not a simple task. A different picture emerges, depending on which aspects of health are included, and there are great challenges in getting accurate data upon which to base any measurement.

This chapter introduces three resources that describe the health of people in Washington; all are available online:

- 2006 Washington Health Foundation Report Card
- Report Card on Health in Washington 2005, by the Department of Health, and
- The Health of Washington State, by the Department of Health

Taken together, they indicate that the people of Washington are above average in levels of health, but we have significant opportunity for improvement.

Finally, a new tool is described, *Local Public Health Indicators*, which will be used in conjunction with performance measurement in public health.

Washington Health Foundation: Comparing Washington to Other States

The Washington Health Foundation (WHF) is a non-profit organization and member of the PHIP partnership. WHF has created a campaign to make Washington State the healthiest state in the nation. To measure progress, they have proposed a set of 17 indicators. The report can be viewed at www.whf.org/documents/report%20card/2006reportcard.pdf.

Figure 5 shows how Washington compares to other states. We are among the top ten on five indicators and fall below half of the states for eight indicators. To become the healthiest state, Washington would need to make significant health improvements.

Report Card on Health

The Report Card on Health was published in 2005 by the Key Health Indicators Committee. It used a health determinants approach, arranging health topics in questions.

Grades were assigned to Washington, much like a school report card. Grades were based on three factors: how we compared to the U.S. as a whole, the trend (getting worse or showing improvement) and whether there

WASHINGTON HEALTH FOUNDATION'S 2006 REPORT CARD

Washington's rank among 50 States*:	
Seat Belt Use	3
Combined Mortality rates	8
Smoking	9
Physical Activity	10
Premature Death	10
Adequate Nutrition	18
Having Health Insurance	19
Binge Drinking	21
Infectious Disease	22
Days of Limited Activity	26
Economic Well-Being	27
Preventive Care	29
Emotional Well-Being	32
Health Care Quality	35
High School Graduation	35
Having Health Home	43
Public Health System Investment	44

*Lower number = lowest rates. The goal is to rank #1.

Source: Washington Health Foundation, *2006 Report Card on Washington's Health*; www.whf.org/documents/report%20card/2006reportcard.pdf

Figure 5

were disparities among racial and ethnic groups.

The indicators were based on data already collected so measures were selected which provided a best fit in answering the health question. The Report Card provides state-level data only because county-level data were not available.

The Report Card questions and overall grades are shown in Figure 6. The full Report Card is available online at www.doh.wa.gov/hip/reportcard/default.htm.

Health Disparities

The Report Card paid special attention to disparities among racial and ethnic groups. The scoring for health disparities is revealed for each indicator in the online report.

From a public health perspective, disparities in the level of health among racial, ethnic, or other groups signal that something is wrong and that population-specific interventions may be needed. Whether due to poverty or discrimination, people who cannot access medical care or who are exposed to greater hazards in their environment are at higher risk for health problems.

The Health of Washington State

The State Department of Health regularly publishes *The Health of Washington State* to serve as a basic resource for people needing information about public health problems.

This biennial report provides Washington-specific data on more than 70 diseases, health conditions, and environmental risks. The categories are shown in Figure 7, next page.

For every item included, a short (four to six page) document is included that provides a summary of the health issue, technical definitions, trends over time, disparities, risk and protective factors, and, where available, geographic variation.

REPORT CARD ON HEALTH, 2005

How healthy are we, overall?

- C Physical and mental health
- C Healthy weight

How safe and supportive are our surroundings?

- B Illness from unsafe food and water
- B Clean drinking water
- A Clean air

How safe and supportive are our communities?

- D Basic financial needs
- B Community connection
- C Injuries

How safe and supportive is our health care system?

- Able to get medical care - insufficient data
- B Illnesses prevented by immunization

How safe and supportive are our families?

- Insufficient data*

*Five measures were evaluated but very limited data were available, so the overall grades were withheld. Rates of child abuse were graded as D and domestic violence as C.

How healthy are our behaviors?

- B Physical activity
- C Eating right
- C Alcohol abuse

Source: Washington State Department of Health, *Report Card on Health in Washington, 2005*; www.doh.wa.gov/hip/reportcard/default.htm

Figure 6

For many of the topics county-level data are included so that differences within Washington can be seen. This local information is very valuable for public health purposes.

THE HEALTH OF WASHINGTON STATE

Categories included in The Health of Washington State:

- The State and Its People - General Characteristics
- Risk and Protective Factors
- Infectious Diseases
- Chronic Diseases
- Injury and Violence
- Maternal and Child Health
- Environmental Health
- Health Care Services
- Occupational Health

Source: *The Health of Washington State, 2002*; www.doh.wa.gov/hws/default.htm

Figure 7

Knowing where a problem occurs and how it varies from one place to the next is critical to selecting intervention strategies.

The 2004 supplement focused specifically on health disparities. *The Health of Washington State and Supplement* can be found at www.doh.wa.gov/hws/default.htm. An updated version of *The Health of Washington State* is due to be published by mid-2007.

A New Tool for Measuring Health in 2007: Local Public Health Indicators

The PHIP Key Health Indicators and Performance Management Committees have developed Local Public Health Indicators, a new tool that will be used as a part of evaluating the performance of Washington's public health system.

The Local Public Health Indicators data will be available online in mid-2007. They will provide county-level

information for about 30 different measures of health, all of which have significant public health implications.

A Diagnostic Tool

The Local Public Health Indicators list is a diagnostic tool. It provides a short list, or dashboard, to reveal the general health of a county's population. The list is only one part of the health information picture. (See Figure 8)

Each county will also have unique data that are important to a deeper understanding of specific local public health concerns.

The Department of Health will continue to publish current reports of many additional health indicators, all of which provide valuable information about health trends.

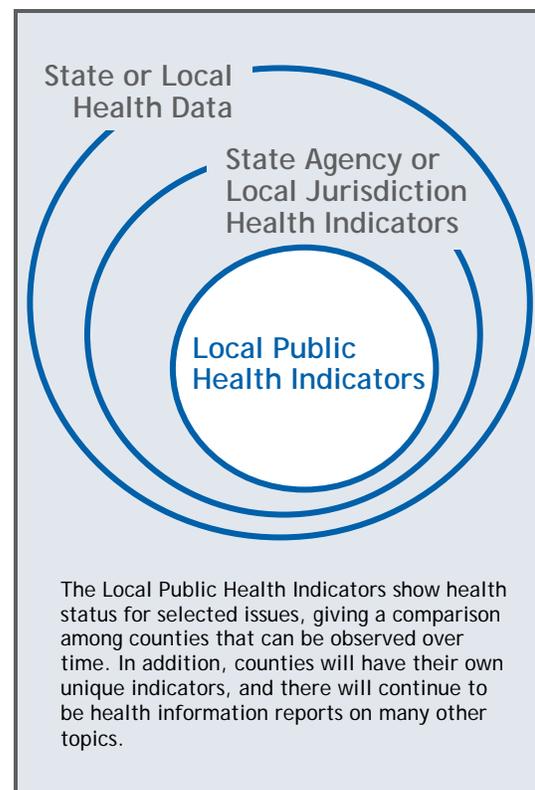


Figure 8

Selecting Indicators

Until now, comparison of health across counties has been difficult. To select the comparable set of indicators, the committee evaluated a large number of potential indicators and available data, applied stringent criteria, and circulated the list widely for comment.

Certain public health indicators, such as Tuberculosis (TB) or HIV/AIDS, were omitted from the final list because very low numbers of cases in some counties made comparing rates among counties unreliable. However, these indicators will continue to be monitored at the state level.

The Local Public Health Indicators are summarized in Figure 9. The full indicator definition and the criteria for inclusion are shown in Appendix 2, Local Public Health Indicators Criteria.

Using Indicators

Local Public Health Indicators will be used in conjunction with the Standards for Public Health, a measurement of basic public health capacity that is conducted every three years. The indicators will provide a powerful tool for targeting specific health issues for improvement, identifying best practices that can be shared, and revealing areas where a lack of basic capacity may have a direct impact on the health of people.

Indicators Have Limitations

This new tool is a beginning but limitations are important to note:

- The factors that determine health are multiple, complex, and inter-related. They are often very hard to measure.
- Health status changes are relatively slow because the underlying determinants of health must be addressed: behavior change, environmental conditions, health services access.
- The Local Public Health Indicators list is expected to change over time, based on experience and emerging health trends.



SUMMARY

In assessing our health, we have to look at the underlying factors that determine health.

How healthy are we? As a state population, we are fortunate to be relatively healthy, but we have room to make significant improvements. We are not the healthiest state in the nation on the measures reviewed, and on some measures we would have to surpass 20 or more states.

We will soon have county-specific data for a standard list of health indicators. These data will be used along with agency-level performance data to target specific health issues and public health system problems that need to be addressed.

In the next chapter, we look at whether it is possible for Washington to raise its scores—and the role that public health efforts can play.

LOCAL PUBLIC HEALTH INDICATORS

These indicators will be used statewide, with comparable county-level data. The exact indicator definition and criteria for inclusion are in Appendix 2 and 3.

Communicable Disease and Epidemiology

- Chlamydia infections and treatment
- Influenza vaccine (age 65+ years)
- Children's immunization status (Medicaid)

Prevention and Health Promotion

- Years of healthy life expected at age 20
- Teen smoking
- Adult smoking
- Physical activity among adults
- Teens overweight
- Adults overweight/obese
- Fruit and vegetables—5 a day
- Teen alcohol use
- Adult binge drinking
- Adults with diabetes
- Adults reporting poor mental health
- Unintentional poisoning

Maternal and Child Health

- Women with 1st trimester pre-natal care
- Pregnant women who smoke
- Teen birth rate
- Babies with low birth weights
- Physical activity among teens
- Children hospitalized for unintentional injury
- Children hospitalized for asthma

Access

- Adults with unmet medical need
- Adults with usual source of health care
- Adults with dental access
- Adult preventive cancer screening
- Adults with health insurance
- Children with health insurance

Environmental Health

- Solid waste facilities in compliance
- Critical violations in food establishments
- On-site sewage systems, corrective actions

County-level data for these local public health indicators will be published at www.doh.wa.gov/phip/documents/khi/material/lphilist.pdf by mid-2007. Each indicator was selected based on ability to conform to stringent criteria; see Appendix 2.

Figure 9



CHAPTER 2: IMPROVING HEALTH

Public Health System Capacity and Priorities

Since 1900, life expectancy in the U.S. has increased by 30 years. Looking back, it is clear that about five of the years gained in life expectancy are directly attributed to improvements in medical care—but the remaining 25 years are the direct results of public health efforts.¹

Public health contributions came primarily from population-based efforts that brought about clean drinking water, safer food handling, widespread immunization efforts, support for healthy pregnancy and childbirth, and removal of environmental contaminants. (See Figure 10)

Given the excellent progress between 1900 and 2000, can public health make similar gains in the next century? Public health officials believe the definitive answer is “yes.” Specific health problems have changed over time, but public health prevention efforts still hold promise for lowering the rates of illness, injury, or premature death in many areas.

THE IMPACT OF PUBLIC HEALTH AGENCIES

The gains made since the turn of the century did not just happen. They are the result of taking actions to improve the health of people, based on the scientific expertise of public health professionals and commitments by policy makers to invest public funds on a large scale.

The first public health departments were created in the late 1800s.

They were charged with protecting and promoting health and served to establish public health as a basic responsibility of government. They contributed to health improvements by guaranteeing consistent attention to health problems and applying standards to protect the whole community.

IMPACT OF PUBLIC HEALTH MEASURES

Life Expectancy

1900: 46.7 years

1998: 76.7 years

Infant Mortality

1900: 110 per thousand births

1998: 7.2 per thousand births

In year 2000, we saw:

- 900,000 fewer cases of measles than in 1941
- 200,000 fewer cases of diphtheria than in 1921
- 250,000 fewer cases of pertussis (whooping cough) than in 1934
- 21,000 fewer cases of polio than in 1951

In addition, we saw:

- 45 million fewer smokers
- 2 million fewer heart disease/stroke deaths
- 100,000 or more people alive in 2000 because of seat belt use.

Source: Turnock, B.J. *Public Health: What it is and how it works*. Jones and Bartlett, Second Ed., 2004.

¹Bunker JP, Frazier HS, Mosteller F. *Improving health: Measuring effects of medical care*. Milbank Q. 1994. 72:225-258.

Figure 10

THE DILEMMA OF PREVENTION

Dr. Bernard Turnock, a professor of public health at University of Illinois, Chicago, writes that if public health were to be reduced to a single word, it would most likely be "prevention." Public health efforts are most often designed to stop something harmful from happening or to reduce the damage from events that cannot be stopped. Prevention efforts may be aimed at deaths, diseases, traffic crashes, premature births, hospitalizations, pollution, or myriad other issues with costly outcomes.

The trouble is that when prevention is successful, the consequences are unseen. The event didn't happen, or the harm was greatly reduced. We go on about our daily lives, unaware that we are reaping the benefits of decades of prevention-based results.

We can calculate huge savings from prevention efforts, but the expenditure and the savings usually happen in different places. For example, we can prevent an epidemic of measles by making sure most people are immunized. A huge part of the cost for immunization programs is paid for by public funds. The benefit is experienced by the people who don't get sick and the health insurers or individuals who did not have to pay for the very expensive consequences of measles. The public benefits by costs avoided, but these costs remain largely unseen.

By contrast, when prevention fails, the consequences are both visible and costly: Between 1989 and 1991, the U.S. saw resurgence in measles that brought 55,000 cases, 11,000 hospitalizations, 120 deaths, and many millions in direct medical cost.

Source: Turnock, B.J. *Public Health: What it is and how it works.* Jones and Bartlett, Second Ed., 2004.

Figure 11

Prevention is the cornerstone of public health's success. Prevention happens when transmission of a disease is stopped, as with immunization, or when a healthy choice replaces behavior that could result in early death or disability. Prevention includes managing vital resources such as keeping drinking water clean and safe. For nearly every public health problem, there is a prevention opportunity. (See Figure 11)



PUBLIC HEALTH AT WORK IN WASHINGTON STATE

To derive the benefits of prevention efforts, Washington needs a strong public health system, with sufficient resources to implement and sustain effective programs.

Washington has a well organized network of local and state agencies that provide the majority of government-based public health services. They implement valuable prevention programs and carry out regulatory efforts to protect the health of people. Most direct services are delivered at the county

level; there are three multi-county jurisdictions. The state Department of Health and other state agencies provide some direct services, but also have a large role in supporting and funding services at the local level. This state-local partnership is fundamental to Washington's public health system.

Assessing Public Health System Capacity

Local and state health officials have created the *Standards for Public Health in Washington State*, required by RCW 43.70.520, which define the basic functional expectations of public health agencies and have developed measures that determine whether the public health system has the capacity needed to meet these expectations. They have written, tested, and applied the standards in three state-wide processes, including a field test (2000), a baseline study (2002), and first measurement (2005).

To assess capacity of the public health system, the standards were organized into five categories of services. These include:

- Protecting People from Disease
- Promoting Healthy Living
- Assuring a Safe, Healthy Environment
- Understanding Health Issues
- Assuring People Get the Services They Need

Washington's public health agencies are not able to fully meet the standards. The consensus of public health officials is that the system is severely under-resourced and will need significant investments, over time, to meet the standards. The results of each

measurement process are reported online at www.doh.wa.gov/hip/perfmgmt/resource/resource.htm.

Part of the measurement process includes collecting and sharing exemplary practices, so that all public health agencies can easily adopt useful tools that help them meet standards. Examples include protocols for response to disease outbreaks, confidentiality policies, and program evaluation tools. While valuable for quality improvement, health officials believe these efforts cannot adequately compensate for a basic lack of resources to address public health needs.

Setting Priorities

Public health leaders have used the standards assessment to consider what specific public health efforts need to be implemented to bring about better health and a stronger public health system. These have been organized, by category, into public health priorities, with estimated costs and possible program-level performance measures attached to each priority. The priorities, summarized in Appendix 5, can be read in detail at www.wacounties.org/wsalpho/workbook%20-%20final.pdf.

The following pages provide information about each category of public health service, including:

- Examples and a description of the types of services provided within a category,
- Summary findings of the capacity of the system to meet the standards in 2005, and
- Priorities for public health services within each category that health officials believe would improve the health of people in Washington.

Protecting People from Disease

This topic covers old diseases, like TB (tuberculosis) and relatively new diseases like HIV/AIDS. When physicians or hospitals see a patient with a communicable disease, one that represents a threat to others, they must report it to public health officials.

There are 39 notifiable conditions that must be reported. Figure 12 shows some of the diseases that were reported in 2005. An annual summary of all disease reports can be viewed at www.doh.wa.gov/notify/survdata/survdata.htm.

Public health officials take whatever action is appropriate to reduce the chance that the disease will be

passed on to others. Figure 13 describes some of the methods public health workers use to control disease.

2005 Standards Results for Communicable Disease

Not all state and local programs are able to fully meet the standards related to this category. In order to meet all standards, health officials estimate basic capacity must increase. There is no dedicated resource for communicable disease services, and the funding available varies greatly among counties.

The results for this category of communicable disease capacity are shown in Figure 14, next page. Complete results are at www.doh.wa.gov/hip/documents/perfmgmt/report/05overallsysstdsassesrprt.pdf for 2005 report.

PREVENTABLE DISEASE

Washington can do better in preventing disease. Each of the cases below consumed significant public health resources and carried large costs to individuals and to public and private health care sectors. They are nearly all preventable.

of cases in Washington 2005

- 256 - Tuberculosis (TB)
- 1,026 - Pertussis
- 18,617 - Chlamydia
- 3,738 - Gonorrhea
- 152 - Syphilis
- 406 - AIDS

(600 to 800 HIV reports per year)

In addition, public health workers responded to 42 food-borne disease outbreaks, affecting approximately 390 people.

Figure 12

CONTROLLING COMMUNICABLE DISEASE

Public health officials take whatever action is appropriate to reduce the spread of disease. Here are some examples of how public health intervenes:

Immunization

Public health agencies provide vaccine and education about the need for immunization to the public and health care providers.

New immunizations are becoming available, and each one represents new work for public health agencies. Recent examples are vaccines to prevent varicella (chicken pox) and, very recently, cervical cancer.

Treatment

Some communicable diseases require treatment to cure individuals and prevent transmission to others.

Tuberculosis (TB) is one example. It has very serious health consequences—and extraordinarily high costs. Treatment takes many months; sometimes the disease becomes resistant to some drugs. Public health workers respond to every case of tuberculosis to assure that treatment is maintained over time and successfully completed.

Counseling and Outreach

Sexually transmitted diseases (STDs) require treatment—plus outreach by public health workers to sexual partners.

Chlamydia is the most widespread STD today, and gonorrhea has re-emerged as a significant problem among some groups.

HIV and AIDS cannot be cured today, so outreach and prevention education are critical. Medication is extending the years of life for people with HIV, but cost per case is huge—about \$600,000 per lifetime in 2006.

Identifying Environmental Contaminants

Some diseases are spread by contaminants in food and water. Public health workers respond quickly to pinpoint the source and remove it. Examples are seen in news reports about *E. coli* O157, Salmonella, or noroviruses in restaurants, in school lunchrooms, or from grocery stores—anywhere people buy and eat food.

Responding to Emerging Disease

Public health workers are usually at the forefront in learning about a new disease. They develop effective responses, provide information to the medical community, and educate the public and media about self-protection. Examples include new diseases like West Nile virus or SARS. Currently, significant public health resources are being directed at the potential for widespread influenza.

Maintaining Vigilance

Recent experience has shown that we cannot afford to let disease prevention efforts lapse. If we do, the old diseases will re-emerge, such as TB or pertussis (whooping cough).

COMMUNICABLE DISEASE STANDARDS – 2005 RESULTS

The standards include the basic functions public health agencies carry out to protect people from disease. Not all state and local programs are able to fully meet these. Results are used to target areas for improvement.

% fully met standard:	DOH*	LHJs*
▫ Disease surveillance and reporting	71%	64%
▫ Response plans with roles and responsibilities	89%	77%
▫ Disease investigation and control procedures	86%	61%
▫ Public information and education about health threats	63%	58%
▫ Review of responses; improve procedures	79%	53%
Overall Score	78%	62%

*Average scores for DOH (Washington State Department of Health) and LHJs (35 local health jurisdictions). Percentages are based on a scoring method that includes 60% of DOH or LHJ programs able to demonstrate performance.

Figure 14

Priorities for Communicable Disease

To improve capacity in this service area, local and state health officials created a list of priorities, including increasing basic funding for:

- Case investigation and outreach
- Disease surveillance tools and epidemiology
- Community awareness resources for broader protection
- Information reporting tools for faster reporting, response
- Surge capacity—ability, to respond to sudden, high demand

A detailed description of priorities for improving public health services can be found at www.wacounties.org/wsalpho/workbook%207%20-%20final.pdf, *Creating a Stronger Public Health System*.

Promoting Healthy Living

A key role of public health is to provide information that people need to make decisions about their health. Often called health promotion, these efforts are rooted in prevention strategies that include public education and setting supportive policy.

The behavioral determinants of health play a large role in health promotion. While the gains in public health in the last century were made in areas of communicable disease, the greatest gains in the next century will likely depend on how well we address health problems that are more often determined by our behavior and social circumstances, not by bacteria, viruses, and toxins.

Two areas for health promotion work by public health agencies are:

- Reducing chronic disease and
- Supporting healthy families.

Reducing Chronic Disease

Public health leaders believe that the most harmful single impact on our health today is tobacco use, followed by the effect of unhealthy diet and lack of physical activity. If we successfully reduce tobacco use and increase healthy lifestyle choices, the expected benefit will be reductions in future medical care costs for preventable conditions and increased quality of life.

Figure 15 outlines some of the achievements and challenges in these areas. Health promotion strategies will also work for many other health problems.

Supporting Healthy Families

By helping families get off to a healthy start, children will experience fewer problems in their later years, with benefits seen in better physical and mental health and improved achievement in learning. Some examples of health promotion programs focused on families are shown in Figure 16.

2005 Standards Results for Health Promotion

Prevention programs and health promotion activities can be based on a very broad range of topics. Rather than a long list of potential topics, Washington's Standards for Public Health include the basic activities public health agencies use to carry out health promotion. The goal is to maximize prevention opportunities by working with many community partners and putting the most effective strategies into practice.

Figure 17 summarizes the overall results of the performance measurement for health promotion. Most health promotion programs are funded in small amounts and they typically address a very specific topic. That means many local health jurisdictions do not have the capacity to develop comprehensive prevention and health promotion programs, nor do they have the resources needed to set community-wide priorities for health improvement.

REDUCING CHRONIC DISEASE

Chronic disease problems can be prevented through public education, an area of specialization for some public health workers. They know that behavior change takes time and rests on the knowledge, attitudes, beliefs, and skills of individuals. Effective health education, coupled with community policy changes, can bring about real changes in health.

Tobacco

Tobacco use has declined in Washington, largely in response to a carefully developed plan that includes statewide counter-advertising plus significant policy changes, such as prohibiting smoking in public places. Tobacco education and enforcement actions take place in every local health jurisdiction.

Gains made: Since 1999, there are 205,000 fewer smokers today in our state. We now have the 5th lowest adult smoking rate in the nation—a leap from 20th in just five years. There are 65,000 fewer teenage smokers today partly because of the youth-targeted efforts carried out statewide by public health workers.

Challenges remain: Nearly 18% of adults in Washington are smokers.

Funds set aside to combat tobacco could be expended by 2011. Without replacement funds, we may lose the gains we've made in recent years.

Obesity

Obesity has been recognized as a national epidemic and is affecting both adults and children. It is the result of eating the wrong foods and not getting enough physical activity in our daily lives. The consequences will be lifelong reductions in health that will show up as heart disease, stroke and diabetes at increasingly younger ages across the population—and will require high medical care costs.

Obesity rates:

- 23% of adults are obese
- 10% of tenth graders are overweight

Diabetes affects 1.4 million people

- 300,000 people have diagnosed diabetes
- 127,000 people have undiagnosed diabetes
- 987,000 people have pre-diabetes

Challenges: To reverse obesity trends, widespread and sustained public health education is needed. However, this is an area with very limited investment today.

As it has with tobacco, public policy can have an impact. To prevent diseases from poor nutrition and inactivity, policy questions might be addressed in every community, including:

- Is the community safely walkable, supportive of physical activity?
- Are fresh, healthy foods readily available?
- Are school children provided opportunity for exercise?
- Is it easy to get help with weight management and diabetes control?

Figure 15

SUPPORTING HEALTHY FAMILIES

Public health programs that emphasize prevention have resulted in positive health outcomes for women and children. This includes higher rates of breastfeeding, reductions in pre-term births and low birth-weight rates, improved health-related behavior, and better education and employment.

Examples of public health efforts in Washington State that support healthy families include:

- The Women, Infants, and Children nutrition program (WIC),
- First Steps Maternity Support Services for pregnant women and newborns,
- immunization programs, and
- CHILD Profile health educational materials and accessible family planning services.

These services do not reach everyone. Many families would benefit from increased investments to promote healthy activities early in a child's life and from policies to support both physical and mental health in children and families.

Home Visiting

Home visiting is one long-standing prevention strategy that improves the health and mental well-being of women, children, and families, particularly those at risk.

Home visiting programs have been shown to reduce costs related to foster care placements, hospitalizations and emergency room visits, unintended pregnancies, and other more costly interventions. Home visiting is more likely to be effective when interventions are based on the family's specific needs and combined with a range of services.

In Washington, many home visiting projects provide services to families. One promising evidence-based program that provides preventive health services to first-time, low-income mothers in their homes is the Nurse Family Partnership, now located in seven Washington State counties.

Source: Olds, D., Henderson, C., Phelps, C., Kitman, H. and Hanks, C. Effect of prenatal and infancy nurse home visitation on government spending. Medical Care 31, 1993. 2:155-174

Figure 16

PROMOTING HEALTHY LIVING – 2005 RESULTS

The standards include basic functions public health agencies carry out to promote health and prevent illness. Not all state and local programs are able to fully meet the standards. Results are used to target areas for improvement.

% fully met standard:	DOH*	LHJs*
▫ Evidence-based prevention policies	65%	65%
▫ Community members help set priorities	63%	57%
▫ Access, information, and collaboration provided	39%	53%
▫ Prevention, intervention, and outreach provided	63%	36%
▫ Community-wide health promotion activities	61%	38%
Overall Score	59%	48%

*Average scores for DOH (Washington State Department of Health) and LHJs (35 local health jurisdictions). Percentages are based on a scoring method that includes 60% of DOH or LHJ programs able to demonstrate performance.

Figure 17

Priorities for Promoting Healthy Living

Public health officials have established priorities for health promotion in two areas:

Reduce the impact of chronic disease

- Support community-level, evidence-based interventions
- Increase ability to track the impact of chronic disease (surveillance and epidemiology)
- Involve health providers in coordinated prevention efforts

Invest in healthy families

- Increase nurse home visiting
- Increase assistance to pregnant women
- Enhance injury prevention
- Provide outreach and access to services for adolescents

A detailed description of priorities for improving public health services can be found at www.wacounties.org/wsalpho/workbook%207%20-%20final.pdf, *Creating a Stronger Public Health System*.

Assuring a Safe and Healthy Environment

Public health is involved whenever there is a potential health threat in the environment, and the threats can come from many sources: drinking water, air pollution, our food supply, lakes or streams, solid waste, leaking septic tanks, insects or animals that carry diseases to humans, to name a few.

Environmental health programs are most visible in the regulatory arena: restaurant inspections, septic tank permits, water system oversight. Yet the greatest amount of time is spent in educating people so that they understand the reasons

behind regulations and have the skills needed to comply. Some of the many issues addressed in environmental health programs are outlined in Figure 18.

2005 Standards Results for Environmental Health

Figure 19 summarizes the overall results of the performance measurement for environmental health. Funding for many environmental health programs is based on fees collected for inspections and permits. The result is that there are few resources to support some areas of great need such as public education programs and response to emerging threats, such as West Nile virus carried by mosquitoes.

ASSURING A SAFE, HEALTHY ENVIRONMENT

Many public health threats arise from the environment. Following are some examples of actions public health workers take to remove health threats.

Assuring Food Safety

Food safety is increasingly complex. The number and types of food vendors has grown dramatically in recent years, and the number and types of foods available have expanded. More products enter our marketplace from other parts of the world so there is greater need for assuring those products are safe from bacterial or chemical contamination.

Public health workers inspect restaurants and grocery stores on a regular basis, enforcing the codes designed to keep food safe in every food establishment in Washington State. All facilities must be inspected at least once per year, and inspections are increased where problems are noted. They can be closed by order of the health department if food-handling problems are not corrected.

Drinking Water Protection

Washington is fortunate to have an abundance of fresh water in many parts of the state. But as the population increases, so does the pressure on this vital resource, making it critical that we keep our drinking water supplies protected and pure.

Washington has 17,344 drinking water systems, each system independently operated. Public health agencies make certain drinking water is managed and tested regularly so it remains safe to use.

On-site Sewage

Many homes in Washington rely on septic tanks for managing sewage. Public health agencies issue permits and oversee the installation of septic tanks because, if improperly installed, they can pollute drinking water resources and expose people to disease.

Emerging Environmental Threats

New health threats emerge from the environment periodically, and each requires that resources be set aside to meet the threat. Examples are:

- Diseases from animals or insects, such as Hanta virus (mice), Lyme disease (ticks), or West Nile virus (mosquitoes). Public health workers collect environmental samples to learn where the disease is present, and they educate medical providers and the public about symptoms and prevention.
- Health concerns in public buildings, such as mold or chemical hazards. Public health workers assess air quality and other sources of exposure and provide information on how to correct problems.
- Toxins are left behind by making methamphetamines. Public health workers determine whether a site has been cleaned well enough to be safe.

Figure 18,
continued

ASSURING A SAFE, HEALTHY ENVIRONMENT – 2005 RESULTS

The standards include basic functions public health agencies carry out to identify and correct environmental health threats. Not all state and local programs are able to fully meet the standards. Results are used to target areas for improvement.

% fully met standard:	DOH*	LHJs*
▫ Public education is part of environmental health programs	97%	54%
▫ Environmental health can respond to threats, disasters	44%	53%
▫ Environmental health risks, illnesses are tracked, and recorded	82%	52%
▫ Compliance with regulations is enforced	60%	54%
Overall Score	69%	53%

*Average scores for DOH (Washington State Department of Health) and LHJs (35 local health jurisdictions). Percentages are based on a scoring method that includes 60% of DOH or LHJ programs able to demonstrate performance.

Figure 19

Priorities for Environmental Health

Public health officials have established priorities for environmental health as:

- Strengthening zoonotics capacity, disease caused by animals and insects
- Increased resources for food safety in high-risk settings

- Water quality information and management

A detailed description of priorities for improving public health services can be found at, www.wacounties.org/wsalpho/workbook%207%20-%20final.pdf.

Understanding Health Issues

State and local public health agencies collect, maintain, and analyze the information that helps identify where there is a significant health problem and whether the trend is increasing or decreasing. Among public health workers, this is called health assessment.

The report cards and ranking described in Chapter 1 are examples of health assessment.

Other typical data include: births and deaths, causes of death, rates of communicable disease, rates of chronic disease, injuries, environmental health problems, and health issues that are just emerging.

Figure 20 describes public health assessment.

2005 Standards Results for Understanding Health Issues

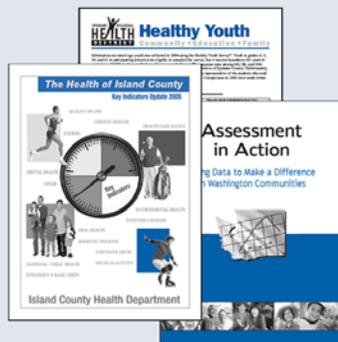
Figure 21 summarizes the overall results of the performance measurement for health assessment. The Institute of Medicine identifies health assessment as a core function of public health. However, the resources needed to collect and maintain information over time are seldom provided. Most public health programs are funded categorically—to address only a specific topic—so cross-cutting capacity such as health assessment gets overlooked. The result is that capacity varies greatly by county. This seriously hampers the ability to do evaluation and base decisions on evidence.

UNDERSTANDING HEALTH ISSUES

Specialized Skills and Tools

People rely on public health agencies as a source of important information. Policy makers, business leaders, budget staff, educators, hospital staff, and many other community partners use health data to set priorities for action, measure progress toward a goal—or sound an alarm when a health threat occurs.

Many health jurisdictions have health assessment staff members who are expert at collecting and analyzing different types of health information. Staff who are epidemiologists provide detailed and complex analyses of health data in order to answer questions such as: Is this rate of cancer abnormally high? Is asthma going untreated and resulting in unnecessary hospitalizations?



Many local health jurisdictions publish documents that describe health issues and support community-based plans for improvement.

Figure 20

UNDERSTANDING HEALTH ISSUES – 2005 RESULTS

The standards include basic functions public health agencies carry out to collect health data and monitor health trends. Not all state and local programs are able to fully meet the standards. Results are used to target areas for improvement.

% fully met standard:	DOH*	LHJs*
▫ Basic assessment skills, tools available	78%	65%
▫ Health data is collected, analyzed, and disseminated	100%	61%
▫ Policy decisions incorporate health assessment results	67%	35%
▫ Public health programs are analyzed and evaluated	91%	56%
▫ Confidentiality of data is protected	63%	72%
Overall Score	75%	56%

*Average scores for DOH (Washington State Department of Health) and LHJs (35 local health jurisdictions). Percentages are based on a scoring method that includes 60% of DOH or LHJ programs able to demonstrate performance.

Figure 21

Priorities to Improve Health Assessment

Public health officials have placed priority on improving health assessment capacity in these specific areas:

- Providing county-level health information to every local jurisdiction to support effective decision-making

- Putting tools in place for effective information management
- Assuring every program is measured and needed changes are identified

A detailed description of priorities for improving public health services can be found at www.wacounties.org/wsapho/workbook%207%20-%20final.pdf, *Creating a Stronger Public Health System*.

Helping People Get the Services They Need

Public health agencies have a strong interest in seeing that everyone gets the health services they need. When medical care in a community is hard to access, the pressure is very evident to people working in public health programs because they make many referrals for needed medical care. Public health agencies may provide some individual health services—immunizations or tuberculosis (TB) treatment, for example—but these are never a substitute for comprehensive medical care or for having a medical home with a clinic or doctor’s office.

Public health jurisdictions often help their communities wrestle with the challenges of building and maintaining an adequate medical care system. They are well positioned to highlight problems,

convene local interest groups, and facilitate local planning to increase the options for medical care.

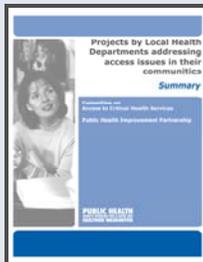
The Access Committee created a compendium of health care access projects in different communities as a way of sharing ideas across many places of our state. It can be viewed at www.doh.wa.gov/phip/access/products/products.htm. Figure 22 describes just one of many examples taken from this resource.

2005 Standards Results for Helping People Get the Services they Need

Figure 23 summarizes the overall results of the performance measurement for access to health services. Public health agencies often become involved in health access issues because of the severe needs experienced by some people they serve. However, there are no funded programs that help address access issues locally and no routine community health planning services at the state or local level.

ACCESS PROJECTS COMPENDIUM

Local health jurisdictions are involved in many community-based efforts to increase access to needed health services. The compendium prepared by the Access Committee describes more than 30 individual projects, covering a wide range of topics:



- General access to health services
- Communicable disease
- Pregnancy and maternal-child health
- Behavioral health
- Cancer
- Oral health
- Other

One example of an access project is the Whatcom Alliance Access Project. It is a community-based consortium that includes outreach materials for all service agencies, care coordination, managing donated specialty care, and recruitment and retention of providers to enhance long-term medical system capacity.

Figure 22

HELPING PEOPLE GET THE SERVICES THEY NEED – 2005 RESULTS

The standards measures include basic functions public health agencies carry out to help people access health services. Not all state and local programs are able to fully meet the standards. Results are used to target areas for improvement.

% fully met standard:	DOH*	LHJs*
▫ Information on local health resources collected	100%	66%
▫ Trends affecting access analyzed	68%	52%
▫ Collaborative plans to reduce access gaps	55%	54%
▫ Quality improvement measures monitored, reported	31%	25%
Overall Score	51%	52%

*Average scores for DOH (Washington State Department of Health) and LHJs (35 local health jurisdictions). Percentages are based on a scoring method that includes 60% of DOH or LHJ programs able to demonstrate performance.

Figure 23

Priorities for Public Health Agencies to Improve Access to Health Services

The priorities set by public health officials to assist in improving access to health services include:

- Expanding availability of translation services; language is a severe access barrier
- Providing the resources to document and monitor local health resources and needs
- Supporting collaborative efforts among public health, health providers, and facilities to plan how to meet community needs
- Providing referral services to everyone who needs help finding care

A detailed description of priorities for improving public health services can be found at www.wacounties.org/wsalpho/workbook%207%20-%20final.pdf, for *Creating a Stronger Public Health System*.



SUMMARY

Washington *can* become healthier. Based on past successes, public health agencies play a critical role in improving and protecting the health of people. If the right investments are made, we can lower communicable disease rates, lower rates of chronic disease, and protect the safety of our basic needs like food and water.

Washington's public health leaders have identified the basic capacity needed at the state and local levels in the *Standards for Public Health in Washington State*.

The public health system is not yet able to fully meet the standards. Improving performance will require additional resources, including workers with specialized skills, information and education programs, improved electronic capability, and evaluation activities to establish effective, evidenced-based practices. Public health officials have set priorities for programs that would yield health improvement.

In the next chapter, we look at how Washington's public health agencies are working together to strengthen the public health system.



CHAPTER 3: WASHINGTON'S PHIP

Creating a Public Health Improvement Partnership

In 1988, the Institute of Medicine published a searing critique of the nation's public health system. The IOM proclaimed the nation's public health system "in disarray," and warned of dire consequences if improvements were not made.

Washington's state and local public health officials responded by forming a unique partnership to address public health as a *system* with common goals. There was general agreement that the IOM findings applied to Washington at that time and that public health resources were stretched unreasonably thin, were uneven from one locale to the next, and were failing to keep pace with contemporary public health issues. A primary goal of the participants was to learn how local and state officials could improve the situation.

By 1993, this effort took form as the Public Health Improvement Plan, required by legislation. The Plan, presented in 1994, was accepted by the legislature and an additional law was put in place in 1995 requiring ongoing development of the PHIP and continual assessment of the system.

PHIP: AN ONGOING PARTNERSHIP FOR IMPROVEMENT

Today, the partnership that supports development of the PHIP includes the organizations noted on the inside cover and on page iv.

The PHIP provides a mechanism for Washington's public health leaders to work in a coordinated manner to

make improvements to the public health system. (See Figure 24) Without this mechanism, it would be very hard to work as a system or coordinate across such a broad range of independent local governments, state agencies, and other organizations.

PUBLIC HEALTH IMPROVEMENT PLAN

A Common Vision for the Public Health System

Washington State's public health partners envision a public health system that promotes good health and provides improved protection from illness and injury for the people of Washington State. Together they are working to improve the public health system in all these areas:

- Setting statewide key health indicators
- Performance measures/standards
- Stable and sufficient funding
- Information technology
- Workforce development
- Access to critical health services
- Communication
- Health partnerships

For complete text of the vision statement, see inside front cover.

Figure 24

Each published plan describes the state of the public health system, the accomplishments of the past

years toward system improvements, and sets forth recommendations for actions in the next years. The documents can be viewed at www.doh.wa.gov/hip/resources/reports/reports.htm.

HOW PHIP WORK IS ORGANIZED

For each element of the vision statement, a statewide multi-disciplinary committee is formed to develop specific steps that can be taken to achieve the vision over time. Each committee has an ambitious work plan, which it carries out in meetings, by phone, and by web conferencing.

A PHIP directors group, representing all the partners, oversees the budget and work plan for the effort. Typically, about 200 people from throughout the public health system combine efforts through all committees' work, bringing together the perspectives and expertise of all the various disciplines in public health practice.

National Recognition

During 2005-06, the Department of Health, in cooperation with PHIP partners, was awarded a grant from the Robert Wood Johnson Foundation and was able to augment projects in the area of performance management. The grant was given in recognition of the groundbreaking work Washington has done in developing standards for public health and measuring our capacity. The grant was renewed for 2006-07.

PHIP ACCOMPLISHMENTS 2006

The current work plan is summarized in Figure 25 and the full text is available online at www.doh.wa.gov/hip/documents/main/hipwrkplnsum05-07.pdf. A brief summary of the work of the PHIP committees' accomplishments follows.

2005-07 PHIP WORKPLAN SUMMARY

Committees and Objectives

- ✓ = completed
- ☐ = complete by June 2007

Key Health Indicators

- ✓ Local Public Health Indicators
- ✓ Evaluate assessment tools
- ☐ Strengthen assessment network

Performance Management

- ✓ Revised standards and measures
- ✓ Select top priority, statewide
- ✓ Develop pilot program measures
- ☐ Training on revised standards

Public Health Finance

- ✓ Publish local finance study
- ✓ Costs to meet standards
- ✓ Issues for legislative study

Workforce Development

- ✓ Training about standards topics
- ☐ Recruitment and retention study
- ✓ Learning management system
- ✓ Orientation to public health

Information Technology

- ☐ Coordinated oversight board
- ✓ Best practices, skills training
- ✓ Business process analysis

Access to Health Services

- ✓ Collect and publish local models
- ✓ Evaluate access indicators

Communications

- ✓ Understanding public health
- ✓ Communications training

Key Health Indicators



Local Public Health Indicators

The *Local Public Health Indicators*, described in Chapter 1, will be used along with the public health standards to evaluate the public health system in 2008. Details of the indicators are found in Appendix 2, *Local Public Health Indicators Criteria*, and online at www.doh.wa.gov/phip/documents/khi/material/lphicriteria.pdf.

The PHIP laws require identification of key health outcomes sought by public health officials. A county-by-county measurement of how each jurisdiction is progressing toward those outcomes is also required.

The lack of robust data systems and the small size of many jurisdictions make it difficult to collect data that are meaningful and can be compared across the state. Establishing this list is a major milestone in linking performance assessment to health outcomes. County-specific data will be online by mid-2007.

Evaluating Assessment Tools

The need for good local health data is paramount. Public health officials need standard information that is accurate and continually updated in order to assess whether interventions are working and to identify emerging health problems.

The Key Health Indicators Committee is assessing what additional information is needed, what is practical to collect, and which data systems can support local health assessment most efficiently.

Strengthening a Health Assessment Network

Washington has built a strong network of health assessment professionals whose expertise is vital to providing local boards of health with the information they need to make decisions. The committee is considering how to support local community health assessment by providing data, useful tools, and technical assistance.

Improving Performance



The PHIP laws require setting standards and measuring performance. In response, Washington's public health officials developed a set of standards for public health, with measures, to gauge whether individual health jurisdictions, and the public health system as a whole, can carry out expected basic functions.

Revised Standards and Measures for Public Health, January 2007

The first standards were organized according to topical areas of public health work (as described in Chapter 2). With experience, health officials decided that the lines between these topics were often blurred—and that an improved set would apply broadly to all programs. As a result, the Performance Management Committee developed the *revised standards*, which delineate 12 functions that every health department should be able to address. (See Figure 26)

The revised standards will be used to measure public health system performance in 2008 and are listed in Appendix 4, Revised Standards for Public Health. All of the standards and measures, plus results from prior measurement can be viewed at www.doh.wa.gov/hip/perfmgmt/product.htm.

Quality Improvement and Evaluation

A key value guiding the development and use of public health standards is an emphasis on quality improvement. Examples of excellent practices are collected and placed on a website so that everyone has easy access to information and tools to help them meet the standards in the future. (See www.doh.wa.gov/hip/documents/perfmgmt/05sep/epreport.pdf)

The 2005 measurement results (available at www.doh.wa.gov/hip/documents/perfmgmt/report/05progrprt.pdf) pointed out many areas where improvement can be made. State and local health officials selected one top priority to receive attention of many public health professionals at the same time.

The top priority is: *Identify specific goals, objectives, and performance measures for LHJs and DOH programs and establish mechanisms for regular monitoring, reporting, and use of results.* This recommendation reflected an overall deficit in program evaluation, including the frequent lack of standard program-level measures of success. A wide range of activities was undertaken to make progress on this recommendation, including training in quality improvement and evaluation, onsite consultations, establishing a peer

learning collaborative, and establishing pilot projects in specific program areas to improve the ability to measure goal achievement.

Training on Using the Standards

To inform staff across the public health system about the revised standards, the Workforce Development Committee is overseeing the development of an online course, to be completed in early 2007. It will be available to every worker, anytime, meeting a demand for just-in-time learning, achieving savings in travel and instructor time. In addition, there will be workshops and in-person training as needed.

2006: TWELVE STANDARDS

- Community Health Assessment
- Communication
- Community Involvement
- Monitoring Public Health Threats
- Responding to Public Health Emergencies
- Prevention and Health Education
- Addressing Gaps in Critical Health Services
- Program Planning and Evaluation
- Financial Management Systems
- Human Resources Systems
- Information Systems
- Leadership and Governance

Figure 26

Public Health Finance



During 2005, the Finance Committee considered funding challenges affecting public health services and estimated the costs of performing at a level that could meet the standards statewide. During 2006, a small workgroup used the committee's previous reports to support the actions of a legislative committee, the Joint Select Committee on Public Health Finance. The report of the Joint Select Committee can be found at www.wacounties.org/wsalpha/workbook%207%20-%20final.pdf.

Study on Funding Challenges Confronting Public Health

The Finance Committee worked with a consulting firm to study trends and issues affecting public health finance. Two related papers, by Berk and Associates, are available at www.doh.wa.gov/philp/finance/products/products.htm.

Overall, the reports found that the public health system was hampered by:

- No dedicated, stable funding source
- Declines in local revenue
- Emerging health threats
- Reliance on categorical funds
- Increasing reliance on fees
- Local funding disparities

Funding in decline: financing in the public health system has not kept pace with increased demand. The analysis showed that, controlled for population increases and inflation, local sources of funding have actually declined by 27% over the past decade for the 34 local health jurisdictions outside King County. Funding had increased from federal sources—but these funds were for specific, new work—and do not compensate for the loss of basic support. Recent months have brought decreases in federal funding for some programs.

Local disparities: the state repealed a dedicated public health tax in 1976, letting counties set their own level of public health support. Thirty years later there are large differences among counties in local funding contribution for public health. Some differences would be expected, reflecting different local needs, but the dramatic range in contributions implies a real differential in basic services. Local investment ranges from \$1.49 to \$36.41 per capita.

Cost to Meet Standards: Estimating Public Health Needs

The Finance Committee developed two models for assessing the level of funding needed in public health, another requirement of the PHIP laws. Health officials from across the state participated in using a common set of assumptions to estimate service gaps and the costs to fill them.

To fully perform the functions they believe are basic, health officials estimate it would take about twice the current expenditure of over \$300 million per year. In 2006,

health officials used the cost analysis to delineate priorities for increasing public health spending in increments of \$50, \$100, and \$200 million per year. This report, *Creating a Stronger Public Health System: Priorities for Statewide Action*, can be viewed at www.wacounties.org/wsalpho/workbook%207%20-%20final.pdf.

of the governmental public health workforce, about 5,400 people from very diverse disciplines including nursing, biology, medicine, sanitation, environmental science and engineering, education, epidemiology, nutrition, communications, and other fields.

HOW LOCAL PUBLIC HEALTH WAS FUNDED IN 2005

The pie chart below shows the source of public health funds for the 35 local health departments.

State sources include those from Department of Health, Department of Social and Health Services, and Department of Ecology and are directed to many different program areas. Federal sources include a broad range of categorical grants from different federal agencies. Local funds vary widely by county, from under \$1.49 per person per year to \$36.41.

Sources of Funds:

\$143 million	Local - all sources
\$ 76 million	State - all sources
\$114 million	Federal - all sources

\$333 million **Total**

Source:

2005 Total revenue reported by local public health
2005 BARS reports

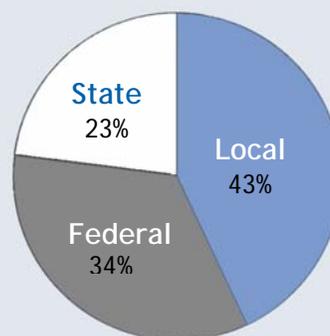


Figure 27

Workforce Development



The Workforce Development Committee is concerned with all aspects

A description of the workforce can be found at www.doh.wa.gov/hip/communications/tools/survey/everybodycounts.

Training on Standards and Topics to Increase Workforce Skills

The public health standards specify 15 different topics in which public health professionals should have training. The Workforce Development Committee is working with the UW Northwest Center for

Public Health Practice to identify existing online courses that will help people access the information they need. In addition, an online course is being developed to prepare workers for the next measurement.

Recruitment and Retention Study

Finding and keeping skilled public health workers can be challenging because a wide range of expertise is needed. In some geographic areas recruitment is difficult, and local wages are below surrounding markets. National studies have indicated that it may be even harder to fill public health vacancies in the future.

The committee, working with the UW Northwest Center for Public Health Practice, is considering topics including local agency recruitment difficulties and what affects retention.

This information will help public health agencies initiate the most effective recruitment efforts (e.g., internet use) and determine if joint recruiting efforts can help reduce costs.

SmartPH: Implementing a Learning Management System

Health information is constantly changing and public health workers need a way to stay informed. Providing workers across the state with the information they need, when and where they need it, is the goal of the learning management system being implemented, called SmartPH. It can be accessed at www.doh.wa.gov/hip/lms_internet/main/main.htm.

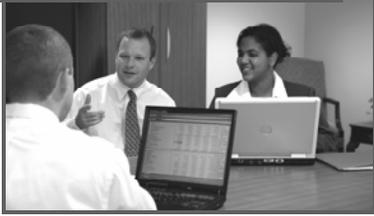
SmartPH is a web-based system. It provides a catalogue of hundreds of courses (both instructor-led and online) to choose from, allows supervisors to assign courses, handles registration, provides a transcript and documents courses completed, and includes an online resources library. The system is now available to all local public health agencies, the state health department, and many partners in emergency preparedness, health clinics, and tribes.

Orientation to Public Health

Many new workers have expertise in a specialized field, but little or no formal education in public health, so the committee has sponsored an online orientation resource. This provides a running start, allowing individuals to compare, borrow, edit, improve on the work of others, and generally expedite the task of preparing materials orienting new staff. This continuously growing collection of resources can be found at www.doh.wa.gov/hip/wfd/resources/category/ph101.htm.

An online orientation is available to local public health leaders, such as health officer, administrator, public health nursing director, environmental health director, and community assessment professional. The program, with discipline-specific modules, can be viewed at www.doh.wa.gov/pho and includes a self-assessment tool that provides assistance in prioritizing learning needs.

Information Technology



Technology makes it easier for public health to work as a system, because information can be shared rapidly with many agencies. However, each county has its own information infrastructure, so they do not all develop in the same direction or at the same pace. The Public Health Information Technology Committee considers how the rapid advancements in technology can be adopted and used effectively in public health.

Statewide Public Health Information Technology (IT) Coordinating Board

New software applications are constantly being developed—often required by a funding agency—to keep records or to inform decisions. Left unchecked, too many separate applications may be developed, requiring additional training, duplicating effort, or resulting in an inability to exchange information.

The committee continues to explore ways to improve software coordination among all public health agencies. This may include an oversight board: a venue and process where public health partners can coordinate planned application development in order to reduce the number of stand-alone applications.

Information Technology Training

To ensure an efficient workforce, workers need basic computer skills. The committee has made funding available in the form of mini-grants to local public health agencies for computer-related training. They are encouraged to use the learning management system to access any of the hundreds of online information technology courses available. Agencies can apply for mini-grants to purchase learning aids, bring instructors onsite, or send staff to instructor-led courses.

Business Process Analysis

Committee members received training on Business Process Analysis (BPA) as one tool to analyze how computer software can address business needs. The process breaks everyday work into detailed transactions to see if the work can be done quicker, with fewer steps. As more processes become automated, this analysis is increasingly important.

Access



The Access Committee is concerned with how public health agencies can assist communities in planning to increase health care access and overcome

local barriers to obtaining needed health services.

Publish Models of Community Access Projects

The committee compiled examples of the many different projects, each designed to improve access to health care and health services. There are over 30 projects representing all aspects of health care, including access to general preventive primary care services, mental and dental health access, and projects focused on other health conditions or diseases. The local health department is often the convener of these community coalitions, but the projects rely heavily on many community partners.

The compendium of community projects can be viewed at www.doh.wa.gov/philp/access/products/products.htm. Project information includes accomplishments and lessons learned for other communities to use in their work on access.

Evaluate Access Indicators

The Access Committee assisted the Key Health Indicators Committee in development of indicators to measure health care access. One important tool is the phone-based survey, the Behavioral Risk Factor Surveillance System. The survey identifies unmet health care needs due to cost, ability to find a health care provider, and/or availability of health insurance; time since last dental visit; and preventive screenings to include mammogram, cervical cancer, and colorectal exams.

Communications



“Public health is an essential function of government, yet it is often misunderstood by the public that it serves.” That was the feedback from elected officials, businesses, and others involved in public knowledge research conducted by the Communications Committee in 2001. The committee chose two strategies to help convey the importance of public health services.

Understanding Public Health

The committee created and launched a public health communications campaign with the purpose of more clearly communicating the value and benefit of public health to the communities we serve. Now in its fourth year, the campaign has been adopted by Washington’s public health agencies in a variety of venues to communicate public health in ways that are meaningful to their respective communities.

“Public Health - Always Working for a Safer and Healthier Washington” has been adopted as a common tagline—a common, easily understood, and recognizable message that can be used by any public health agency. The committee work also included identifying what services in public health are important to different groups. (See www.doh.wa.gov/philp/communications/tools)

Workforce Training

Since 2002, approximately 300 public health professionals have been trained in how to incorporate strong descriptive messages into their everyday communications. Many local health jurisdictions have inserted the words “public health” into their agency names, and key themes are reflected in annual reports, public testimony, news releases, and educational materials.

Training is augmented with a tool kit containing clear and compelling messages about public health and is supported by a web-based resource library of communications tools. Workers have found that having a tool kit available saves time and improves the quality of their messages. An example is shown in Figure 28. (See also www.doh.wa.gov/phip/communications/tools/tools.htm)

PUBLIC HEALTH

Always Working for a Safer and Healthier Washington

Public health agencies in Washington provide critical programs and services for all people in the state—from drinking water protection to disease prevention. The public health network coordinates at the local, statewide, and national level to keep our communities healthy and safe. The work of public health includes:

- ***Essential Programs for Improving Health***

Programs such as immunizations, communicable disease prevention, and chronic disease and injury prevention help individuals and communities stay healthy.

- ***Information that Works***

Resources such as educational and training programs, community health reports, and statewide health and safety information provide individuals and communities information they can use to make good decisions.

- ***Protecting You and Your Family Every Day***

Services such as drinking water and air quality monitoring, septic system inspections, restaurant inspections, disease prevention, and planned community crisis response ensure individual and community health and safety.

Figure 28

SUMMARY OF RECOMMENDED NEXT STEPS

The PHIP committees have completed most of the objectives set for 2005-07, with some work continuing to June 2007. The next steps recommended by each committee will form the basis of a work plan for 2007-09. The objectives are provided on pages ix - x of this report and a summary provided below, Figure 29.

PHIP COMMITTEE OBJECTIVES

<i>2005-07 Completed Objectives</i>	<i>2007-09 Planned Objectives</i>
<p>Key Health Indicators</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Local Public Health Indicators <input checked="" type="checkbox"/> Evaluate assessment tools <input type="checkbox"/> Strengthen assessment network 	<p>Key Health Indicators</p> <ul style="list-style-type: none"> <input type="checkbox"/> County data online <input type="checkbox"/> Funding to collect local data <input type="checkbox"/> Local assessment tools
<p>Performance Management</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Revised standards and measures <input checked="" type="checkbox"/> Select top priority, statewide <input checked="" type="checkbox"/> Develop pilot program measures <input type="checkbox"/> Training on revised standards 	<p>Performance Management</p> <ul style="list-style-type: none"> <input type="checkbox"/> Training on revised standards <input type="checkbox"/> Communication, tools on process <input type="checkbox"/> Self-assessment guide <input type="checkbox"/> Training on results
<p>Public Health Finance</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Publish local finance study <input checked="" type="checkbox"/> Costs to meet standards <input checked="" type="checkbox"/> Issues for legislative study 	<p>Public Health Finance</p> <ul style="list-style-type: none"> <input type="checkbox"/> Continue allocations work <input type="checkbox"/> Any new administration, oversight
<p>Workforce Development</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Training about standards topics <input type="checkbox"/> Recruitment and retention study <input checked="" type="checkbox"/> Learning management system <input checked="" type="checkbox"/> Orientation to public health 	<p>Workforce Development</p> <ul style="list-style-type: none"> <input type="checkbox"/> Complete orientation materials <input type="checkbox"/> Training for 2008 measurement <input type="checkbox"/> Priority training needs
<p>Information Technology</p> <ul style="list-style-type: none"> <input type="checkbox"/> Plan coordinated oversight board <input checked="" type="checkbox"/> Best practices, skills training <input checked="" type="checkbox"/> Business process analysis training 	<p>Information Technology</p> <ul style="list-style-type: none"> <input type="checkbox"/> Start coordinated oversight board <input type="checkbox"/> Best practices, skills training <input type="checkbox"/> Use business process analysis
<p>Access to Health Services</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Collect and publish local models <input checked="" type="checkbox"/> Evaluate access indicators 	<p><i>Incorporated with Key Health Indicators</i></p>
<p>Communications</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Understanding public health <input checked="" type="checkbox"/> Communications training 	<p>Communications</p> <ul style="list-style-type: none"> <input type="checkbox"/> Training for public health workers <input type="checkbox"/> Outreach to business sector

Figure 29



Appendix 1: PHIP Laws

Appendix 2: Local Public Health Indicators Criteria

Appendix 3: Local Public Health Indicators List and Matrix

Appendix 4: Revised Standards for Public Health

Appendix 5: Priorities for Public Health Funding

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 (8) 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

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 492E 467.]

RCW 43.70.580

Public health improvement plan—Funds—Performance-based contracts—Rules—Evaluation and report.

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 43, Laws of 1995.

(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.

[1995 c 43E 3.]

APPENDIX 2: LOCAL PUBLIC HEALTH INDICATORS CRITERIA

A joint subcommittee of the Key Health Indicators Committee and Performance Management Committee established criteria for selecting the set of local public health indicators. These criteria were included on an indicator matrix (Appendix 3) and the subcommittee evaluated each potential indicator against all 11 criteria.

These criteria are:

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

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

APPENDIX 3: LOCAL PUBLIC HEALTH INDICATORS LIST AND MATRIX

List of Local Public Health Indicators

1. Rate of reported Chlamydia infections (women 15-24 years)
2. Percent of reported adequate Chlamydia treatment for females 15-24 years
3. Influenza vaccine during previous year for 65+ years
4. Childhood immunization—percent of Medicaid (Healthy Options) children who are adequately immunized by two years of age
5. Expected years of healthy life at age 20
6. Percent of 10th graders who report smoking in last 30 days
7. Percent of adults who report meeting moderate or vigorous physical activity
8. Percent of adults who report binge drinking on one or more occasion in past 30 days
9. Percent of adults who report smoking everyday or some days
10. Percent of adults who are obese and overweight—BMI
11. Percent of adults who report diagnosis of diabetes
12. Percent of adults who report 14 or more days of poor mental health in past month
13. Percent of 10th graders who report alcohol consumption in past 30 days
14. Percent of 10th graders who are overweight—BMI
15. Percent of adults who report eating fruits and vegetables 5 or more times per day
16. Unintentional poisoning hospital rates per 100,000 (all ages)
17. Percent of women who received prenatal care during 1st trimester
18. Percent of pregnant women who smoke during 2nd/3rd trimester of pregnancy
19. Birth rate for females (age 15-17)
20. Percent of low birth-weight rate among singletons (less than 2,500g, 3-year average)
21. Percent of 10th graders who report having met recommendations for vigorous physical activity
22. Unintentional injury hospitalizations (age 0-17, 3-year average)
23. Asthma hospitalizations (age 0-17, 3-year average)
24. Percent of adults in households who report unmet medical need due to cost
25. Percent of adults who report usual source of health care
26. Percent of adults who report having visited dentist in past year
27. Percent of adults who report receiving preventive cancer screenings, e.g., breast, cervical, colorectal
28. Percent of adults who report having health insurance
29. Percent of children who are reported as having insurance
30. Permitted solid waste facilities in compliance with permit conditions
31. Percent of inspections of permanent food establishments with 35 or more critical violations (CV) points
32. Percent of identified on-site sewage system failures initiated with corrective action within 2 weeks

Local Public Health Indicators Matrix

Local Public Health Indicators	Data Availability			Data Source (e.g., BRFSS, etc.)	Population- Based	Important Aspect Hi/Med/Lo
	NTL	ST	CO			
1. Rate of reported Chlamydia infections (women 15-24 years)	Y	Y	Y	CFH	Y	M
2. % reported adequate Chlamydia treatment for females 15-24 years	N	Y	Y	CFH	Y	M
3. Influenza vaccine during previous year for 65+ years	Y	Y	Y	BRFSS	Y	M
4. Childhood immunization - % of Medicaid (Healthy Options) children who are adequately immunized by age 2	Y	N	N	CFH	N	H
5. Expected years of healthy life at age 20	Y	Y	Y	BRFSS, VS	Y	H
6. % 10 th graders who report smoking in last 30 days	Y	Y	Y	HYS	Y	H
7. % of adults who report meeting moderate or vigorous physical activity	Y	Y	Y	BRFSS	Y	H
8. % of adults who report binge drinking on one or more occasion in past 30 days	Y	Y	Y	BRFSS	Y	M
9. % of adults who report smoking everyday or some days	Y	Y	Y	BRFSS	Y	H
10. % of adults who are obese and overweight—BMI	Y	Y	Y	BRFSS	Y	H
11. % adults who report diagnosis of diabetes	Y	Y	Y	BRFSS	Y	H
12. % adults who report 14 or more days of poor mental health in past month	Y	Y	Y	BRFSS	Y	H
13. % 10 th graders who report alcohol consumption in past 30 days	Y	Y	Y	HYS	Y	M
14. % of 10 th graders who are overweight—BMI	Y	Y	Y	HYS	Y	H
15. % of adults who report eating fruits and vegetables 5 or > times per day	Y	Y	Y	BRFSS	Y	H
16. Unintentional poisoning hospital rates per 100,000 (all ages)	Y	Y	Y	CHARS	Y	H

Measurable	Actionable Contr/Influ	Measure HD/HS	Trend Data	Links to Other Measures	Demo-graphic	Under-standable	Comments/ Data Validity	Used in WA Report Card
Y	I	HS	Y	Y	Y	Y	2004 - 1 county: 0, 1 county: 3, others > 5 cases	
Y	I	HD	Y	Y	Y	Y	poor compliance with reporting	
Y	I	HD	Y	N	Y	Y	maybe expand BRFS?	
Y	I	HD	N	N	Y	Y	representative of Medicaid population, CHILD Profile is desired data source once increased use	
Y	I	HS	Y	Y	Y	Y		WA RC
Y	I	HD	Y	Y	Y	Y	HP 2010 16-17c (different grades)	WA RC
Y	I	HD	Y	Y	Y	Y		WA RC
Y	I	HD	Y	Y	Y	Y		WA RC
Y	I	HD	Y	HP 2010	Y	Y		WA RC
Y	I	HS	Y	Y	Y	Y	with caution (accuracy questionable), with definition of calculation	WA RC
Y	I	HS	Y	Y	Y	Y		
Y	I	HS	Y	Y	Y	Y	low #s for adults for some counties	WA RC
Y	I	HD	Y	Y	Y	Y	HP 2010 16-17a (different grades)	WA RC
Y	I	HD	N	Y	Y	Y		WA RC
Y	I	HD	Y	Y	Y	Y	does not use serving size	WA RC
Y	I	HD	Y	Y	Y	Y	includes Washington residents hospitalized in Oregon, but not in other states, does not include military data	WA RC

Local Public Health Indicators Matrix (cont'd)

Local Public Health Indicators	Data Availability			Data Source (e.g., BRFSS, etc.)	Population- Based	Important Aspect Hi/Med/Lo
	NTL	ST	CO			
17. % of women who received prenatal care during 1 st trimester	Y	Y	Y	Vital Records	Y	H
18. % of pregnant women who smoke during 2 nd /3 rd trimester pregnancy	Y	Y	Y	Vital Records	Y	H
19. Birth rate for females (age 15-17)	Y	Y	Y	Vital Records	Y	H
20. % low birth weight rate among singletons (< 2,500g, 3 year average)	Y	Y	Y	Vital Records	Y	H
21. % 10 th graders who report having met recommendations for vigorous physical activity	Y	Y	Y	HYS	Y	H
22. Unintentional injury hospitalizations (age 0-17, 3 year average)	?	Y	Y	CHARS	Y	H
23. Asthma hospitalizations (age 0-17, 3 year average)	?	Y	Y	CHARS	Y	M
24. % of adults in households who report unmet medical need due to cost	Y	Y	Y	BRFSS	Y	Y
25. % of adults who report usual source of health care	N	2005	Y	BRFSS	Y	Y
26. % of adults who report having visited dentist in past year	Y	Y	Y	BRFSS	Y	Y
27. % adults who report receiving preventative cancer screenings - breast, cervical, colorectal	N	Y	Y	BRFSS	Y	Y
28. % adults who report having health insurance	N	state	Y	BRFSS	Y	Y
29. % children who are reported as having insurance	N	state	Y	BRFSS	Y	Y
30. % permitted solid waste facilities in compliance with permit conditions	N	Y	Y	Ecology	N	M-H
31. % inspections of permanent food establishments with 35 or more CV points	N	Y	Y	DOH/Local N	N	H
32. % identified on-site sewage system failures initiated with corrective action within 2 weeks	N	Y	Y	DOH/Local N	N	H

Measurable	Actionable Contr/Influ	Measure HD/HS	Trend Data	Links to Other Measures	Demo-graphic	Under-standable	Comments/ Data Validity	Used in WA Report Card
Y	I	HD	Y, after 2003	HP 2010 - 16-6a	Y	Y	> 20% unknowns	
Y	I	HS	Y, after 2003	HP 2010 - 16-17c	Y	Y	PRAMS data was used for RC on smoking in 3 rd trimester	WA RC
Y	I	HD	Y	HP 2010	Y	Y		
Y	I	HD	Y	HP 2010 - 16-10a	Y	Y		
Y	I	HD	Y	HP 2010 - 22-7 (grade 9)	Y	Y		WA RC
Y	I	HS	Y	HP 2010 - cause specific	N	Y	some data for border counties and military hospitals	
Y	I	HS	Y	HP 2010 - 1-9a	N	Y	may switch to hospitalization for ambulatory care sensitive conditions; unable to report border counties and counties with major military hospitals.	
Y	I	HD	Y	Y	Y	Y	data even years	
Y	I	HD	Y	Y	Y	Y		
Y	I	HD	Y	Y	Y	Y		
Y	I	HD	Y	Y	Y	Y		
Y	I	HD	Y	Y	Y	Y	recommended new question for 2007	
Y	C	HD	Y	Y	N	Y		
Y	C	HD	Y	Y	N	Y		
Y	C	HD	Y	Y	N	Y	pilot study is collecting this data	

APPENDIX 4: REVISED STANDARDS FOR PUBLIC HEALTH

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

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

The standards are the same for state and local agencies. Under each of these standards, there are measures that are specific either to local health jurisdictions or to the State Board of Health and Department of Health.

Standard 1: Community Health Assessment

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

Standard 2: Communication to the Public and Key Stakeholders

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

Standard 3: Community Involvement

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

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

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

Standard 5: Planning for and Responding to Public Health Emergencies

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

Standard 6: Prevention and Education

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

Standard 7: Helping Communities Address Gaps in Critical Health Services

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

Standard 8: Program Planning and Evaluation

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

Standard 9: Financial and Management Systems

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

Standard 10: Human Resource Systems

Human resource systems and services support the public health workforce.

Standard 11: Information Systems

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

Standard 12: Leadership and Governance

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

APPENDIX 5: PRIORITIES FOR PUBLIC HEALTH FUNDING

Summary of Public Health Priority Actions

In 2006, local public health officials collaborated on a detailed listing of priorities they believe should be addressed to improve the health of people in Washington. Full descriptions of the priorities, budget estimates, and potential performance measurements are discussed in the document, *Creating a Stronger Public Health System*, available at www.wacounties.org/wsalpho/Workbook%207%20-%20Final.pdf.

Stop Communicable Diseases Before They Spread:

- Case investigation and outreach
- Disease surveillance and epidemiology
- Raising community awareness for better protection
- Managing information for faster reporting and response
- Maintaining surge capacity and emergency response plans

Reduce the Impact of Chronic Diseases:

- Evidence-based interventions to prevent disease
- Surveillance and epidemiology of chronic disease trends
- Engage health providers in coordinated prevention efforts

Invest in Healthy Families:

- Nurse home-visit programs for high-risk families
- Supportive services for pregnant women
- Injury prevention
- Outreach and treatment for adolescents

Protect Safety of Drinking Water, Food and Air:

- Zoonotics: diseases from animals, insects, parasites
- Water quality control and on-site maintenance
- Food safety protection

Use Health Information to Guide Decisions:

- Support collection of local data that is specific and timely
- Analysis tools for local data to monitor trends
- Infrastructure for electronic data

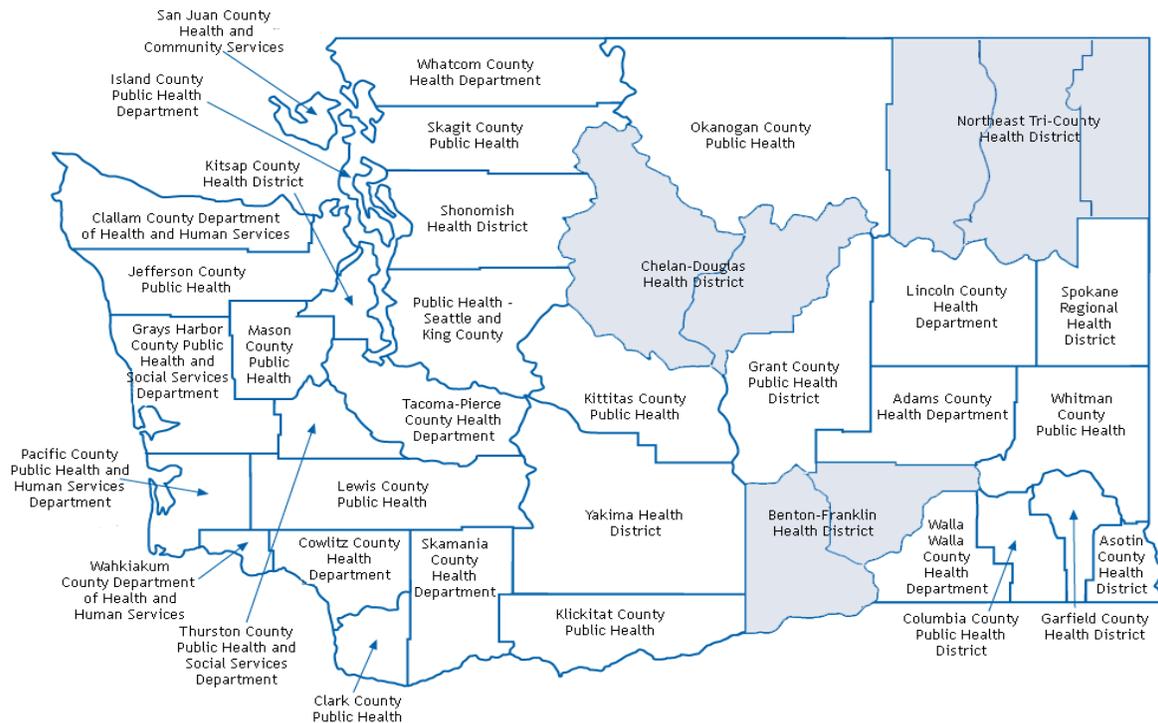
Help People Get the Health Services They Need:

- Translation services and materials
- Identify specific, local problems in access to care
- Engage community partners; address local service gaps
- Assist people in finding medical homes

WASHINGTON STATE PUBLIC HEALTH SYSTEM

Washington's Governmental Public Health System Includes:

- 35 local public health jurisdictions, three with multiple counties
- Washington State Department of Health and other state agencies
- Washington State Board of Health



Public Health Improvement Plan Partners

Washington State Department of Health

Washington State Association of Local Public Health Officials

Washington State Board of Health

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

Washington Health Foundation

American Indian Health Commission for Washington State

Washington State Public Health Association

These agencies collaborate to develop the Public Health Improvement Plan and implement the recommendations and findings included in the plan.



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