State of Washington
Joint Legislative Audit and Review Committee (JLARC)

Review of Washington's Public Health System

Report 07-8

May 30, 2007

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Committee Approval

On May 30, 2007, this report was approved for distribution by the Joint Legislative Audit and Review Committee.

Acknowledgements

We appreciate the time and input from the state Department of Health and the local health jurisdictions during the course of this study.

REVIEW OF
WASHINGTON'S PUBLIC
HEALTH SYSTEM

REPORT 07-8

REPORT SUMMARY

MAY 30, 2007

STATE OF WASHINGTON

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Report Summary

Washington's public health system touches the residents of the state in many ways, from drinking water and food safety inspections, to health education and disease prevention, to maintaining our birth and death records.

As part of its 2005-07 work plan, the Joint Legislative Audit and Review Committee (JLARC) chose to review the state's public health system. This review covers three areas: (1) the structure of Washington's public health system; (2) statutory reporting requirements on system performance and evolution of the implementation of these requirements; and (3) information available on the consistency of public health service provision at the local level.

Structure of the System

Washington has a decentralized public health system rather than a state-run or state-directed system. There are 35 local health jurisdictions, each with a local governing board of health. Most are organized along county boundaries, though there are three multi-county jurisdictions. Local health jurisdictions act as the "action arms" of the public health system, providing the bulk of direct services. The local boards of health have discretion in how to best meet their public health obligations, deciding which public health programs to invest in and at what level of funding.

The state Department of Health is the state's primary public health agency. The Department provides some public health services directly, for example, through the state's public health laboratory. The Department works with the local jurisdictions, providing services through consultation, technical assistance, training, and other avenues. The Department acts as the contracting agency to the local jurisdictions for a number of different state and federal funds to support a variety of activities. The Department also has broad emergency powers to intervene at the local level in emergency situations; however, the agency has not formally exercised this authority in recent history.

Washington's public health system is funded through a complex mix of federal, state, and local funds, including permits and user fees. Many of the state and federal funds may only be used for specific programs or services.

Washington shares this decentralized public health system structure with 29 other states. The remaining states have systems that are either state-administered (8 states) or have a blend of state and local authority over public health (12 states).

Statutory Performance Reporting Requirements

The Legislature established public health system performance reporting requirements in 1993 and 1995, using the mechanism of a biennial Public Health Improvement Plan. The Department of Health and its public health partners were slow to implement these requirements, but measures and assessment processes are in place now and continue to evolve. These performance reporting systems are based on minimum standards for public health protection, system capacity, and key public health indicators.

State and local public health agencies currently are not meeting the minimum standards, and officials from these agencies do not expect to be able to do so without an investment of additional resources. A new assessment using a revised set of standards will take place in 2008. The assessments on standards and the estimate of the cost to bring agencies up to these standards are used to gauge system capacity. For key public health indicators, the Department of Health and its partners published a Report Card on Health in Washington in 2005. Much of the information in the Report Card is on a statewide basis. A report on health indicators at the local level is expected in mid-2007 using a newly developed set of local public health indicators.

Public health officials, the Legislature, and other interested parties will continue to want information about the performance of the state's public health system. Given the evolution in the implementation of performance reporting, the time may be right to review and update the language in the state's performance reporting statutes.

Consistency in Public Health Service Delivery at the Local Level

Standardized information is not currently available to paint a complete picture of the choices being made at the local level for public health service delivery. Information that is available shows wide variation in public health expenditures (both in total and per person) and in local jurisdictions' ability to meet the minimum public health standards. Information on local public health indicators is expected later this year. The Department of Health and its partners are also launching a new effort to create an inventory of public health services that would document both the type and the amount of services provided in each local health jurisdiction.

Study Recommendation

The Department of Health should review the statutory language used to describe the performance reporting requirements for the public health system and make suggestions to update the language in light of current practices, while maintaining requirements to provide important performance information. As part of its review, the Department should identify appropriate language to link contracted funds with performance. The Department should deliver its suggested changes to the language in the public health performance reporting statutes in a report to the Legislature by January 2008.

CHAPTER ONE – INTRODUCTION

From health education and disease intervention, to drinking water and food safety inspections, to maintaining birth and death records, Washington's public health system touches the lives of virtually every person in the state. As part of its 2005-07 work plan, the Joint Legislative Audit and Review Committee (JLARC) chose to review the state's public health system. This review covers three areas: (1) the structure of Washington's public health system; (2) statutory reporting requirements on the performance of that system and the evolution in the implementation of those statutory reporting requirements; and (3) information available on the consistency of public health service provision at the local level.

Before moving into these topics, this first chapter introduces the concept of "public health" and also describes another public health-related legislative effort underway at the same time as this JLARC study; that parallel effort focuses on the financing of the state's public health system.

Background

What Is Public Health?

Statute defines "public health" as "activities that society does collectively to assure the conditions in which people can be healthy" (RCW 43.70.575(6)). In practical terms, public health encompasses a broad range of activities, which Washington's Department of Health has grouped into five areas:

- Assuring a safe and healthy environment;
- Protecting people from disease;
- Understanding health issues;
- Prevention and health promotion; and
- Access: Helping people get the services they need.

Figure 1 on the following page depicts the many types of services and activities that fall under each of these functional areas. The wide reach of public health ranges from ensuring basic sanitation, to an emphasis on disease prevention, to preparing for and being able to respond to such varied threats as E.coli outbreaks, pandemic flu, or incidents of bio-terrorism.

Another way of thinking about public health is that it includes those services and activities that government does to help ensure the health of *the public as a whole*, rather than the health of an individual person.

A Separate Legislative Study on Public Health Financing

In 2005, the Legislature enacted Engrossed House Concurrent Resolution 4410, which created the Joint Select Committee on Public Health Finance. The Committee was made up of eight legislators representing the four major caucuses, and the resolution charged the Committee to review all current and potential local, state, and federal funding sources and expenditures for public health services and to recommend potential sources of future funding for public health services.

Figure 1 – Public Health Services by Broad Functional Area:
"Public Health" Includes a Wide Range of Services and Activities

Assuring a Safe and Healthy Environment

- Drinking water
- Food safety (e.g., inspections)
- Water recreation facilities
- Drug lab site recovery
- Solid waste
- Sewage
- Controlling rodents, insects
- Air quality and safety
- School safety
- Land Use review

Protecting People From Disease

- Disease detection
- Diagnosis
- Case finding
- Disease reporting
- Laboratory
- Emergency disease response
- Provider education
- Immunizations
- Drug Therapy
- Tracking disease trends
- Outreach to high risk
- Prevention education
- Media, communications

Understanding Health Issues

- Tracking disease trends
- Documenting health behaviors
- Data analysis
- Birth and death data
- Community health assessment
- Evaluating program results
- Evidence-based decision support
- Technical assistance to community
- Estimating cost benefits & impacts

Prevention and Health Promotion

- Health education
- Early intervention
- Outreach
- Funding community services
- Strategic planning
- Community mobilization

The services above are performed for such diseases and issues as:

- Diabetes
- Heart disease
- Stroke
- Tobacco
- HIV/AIDS
- Injury
- Drug use
- Alcohol abuse
- Physical activity
- Nutrition
- Maternal-Child health
- Women, Infant, Children (WIC)
- Family Planning
- Adolescent health

Access: Helping People Get the Services They Need

- Documenting service needs
- Referral to providers
- Service coordination
- Community planning
- Provider relationships
- Limited medical services
- Policy and advocacy

Source: Based on information provided by the Department of Health to the Joint Select Committee on Public Health Finance, 2006.

The Joint Select Committee transmitted its report to the Legislature in November 2006. Its recommendations include a call for approximately $50 million annually in additional state funds during the 2007-09 Biennium for the public health system, as an initial investment. Additional recommendations touch on local funding for public health activities, long-term overall funding for public health, and the concept of a set of core public health functions being consistently available (with performance measured) in all parts of the state. The Legislature subsequently appropriated $9.5 million per year in additional funding for local health jurisdictions. It also passed Engrossed Second Substitute Senate Bill 5930, which directed the Department of Health to adopt a prioritized list of core public health functions of statewide significance and associated performance measures.

Because the Joint Select Committee was charged to examine public health financing, this JLARC study did not delve into financing issues.

Study Methodology

To conduct this review,

- We requested information from the state Department of Health, and we reviewed statutes, reports, data, and other materials pertinent to our subject;
- We conducted interviews with Directors or Administrators representing each of the state's local health jurisdictions and with representatives of the state Department of Health;
- We monitored the work of the Joint Select Committee on Public Health Finance; and
- We contracted with a consultant to examine the structure of public health systems in other states.

Organization of the Report

Chapter 2 describes the structure of the state's decentralized public health system, including identification of the specific roles of the 35 local health jurisdictions and the state Department of Health. The chapter also includes information on how the system is funded, how the structure in Washington compares to that of other states, and local and Department perspectives on current operation of the system.

Chapter 3 identifies two primary reporting mechanisms the Legislature installed in statute as part of a biennial Public Health Improvement Plan to provide public health officials, the Legislature, and other interested parties with information on the performance of the state's public health system. The chapter further discusses how the implementation of these reporting requirements has evolved over time, while the statutory provisions have remained static. This chapter also notes other materials available on the status of public health in Washington. The chapter closes with a discussion on whether it may be time to revisit the performance reporting statutes.

Chapter 4 covers the information available on the consistency of public health service provision at the local level. Currently the information available is inadequate for making full comparisons about service delivery and health outcomes at the local jurisdiction level, though information is available on local jurisdiction public health expenditures and performance in meeting the state's

public health standards. This chapter also describes efforts underway to provide additional information on public health services at the local jurisdiction level in the future.

Chapter 5 provides a summary of the study and revisits the one study recommendation.

CHAPTER TWO – THE STRUCTURE OF WASHINGTON'S PUBLIC HEALTH SYSTEM

Washington's public health system is a decentralized, locally based system; it is not a state-run or state-directed system. Thinking broadly, this system includes state and local governments, health care providers, hospitals, federal funding agencies, and a number of other system participants. However, this chapter focuses on the roles of two key participants in Washington's public health system: the state's 35 local health jurisdictions, and the state Department of Health. The chapter also describes how the current system is funded and how public health systems are structured in other states, and provides perspectives on the current operation of Washington's system.

Local Health Jurisdictions

Statute vests primary day-to-day authority and responsibility for public health in the state's local jurisdictions, through the local boards of health: "Each local board of health shall have supervision over all matters pertaining to the preservation of the life and health of the people within its jurisdiction" (RCW 70.05.060). This same statute requires the local boards of health to:

- Enforce the state's public health statutes and rules;
- Supervise the maintenance of all health and sanitary measures for the protection of the public health within its jurisdiction;
- Enact local rules and regulations that are necessary to preserve, promote, and improve the public health and to provide for public health enforcement;
- Provide for the control and prevention of any dangerous, contagious or infectious disease within the jurisdiction of the local health department;
- Provide for the prevention, control, and abatement of nuisances detrimental to the public health;
- Make required reports to the state Board of Health; and
- Establish fee schedules for issuing or renewing certain public health-related licenses or permits.

These local health jurisdictions act as the "action arms" of the public health system, providing the bulk of direct services. However, local jurisdictions often have discretion in determining how best to address these statutory requirements. The Department of Health explains that local jurisdictions emphasize the variability in populations and disease issues from one locale to the next, and jurisdictions feel that their purpose is to respond to the specific needs of the people they serve. In practice, one local jurisdiction may choose to offer a public health service while another does not. The local boards of health decide which programs to invest in and at what level of funding.

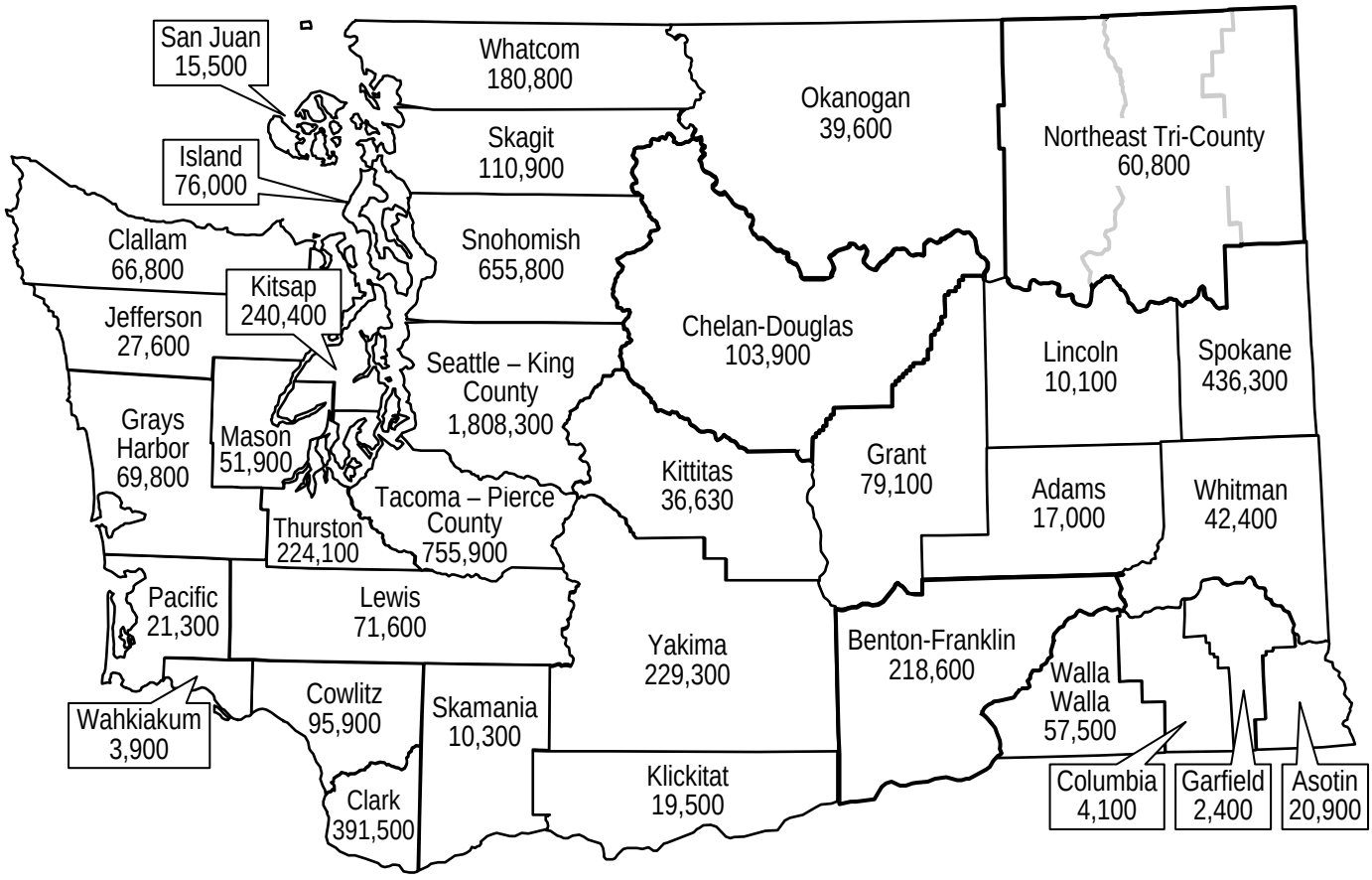
Currently there are 35 local health jurisdictions operating in the state. Local jurisdictions may be organized on a single- or a multi-county basis, and as a "department" (within a county government) or a "district" (which exists as a separate political subdivision). Of the state's 35 local public health jurisdictions,

- 21 are single-county departments;
- 2 are combined city-county departments (Seattle-King County and Tacoma-Pierce County);
- 9 are single-county districts; and
- 3 are multi-county districts (accounting for 7 counties).

In single-county departments, the county commissioners serve as the local board of health, although the commissioners may expand the board. The city-county departments have inter-local agreements that outline the composition of their boards. In districts, the local boards of health are generally larger than those of departments and typically include both county and city representation.

Figure 2 below shows a map of Washington's 35 local health jurisdictions. The map also includes the 2005 population levels for each local jurisdiction. There is great variation in

Figure 2 – Washington's 35 Local Health Jurisdictions (2005 Population Levels)



Source: Department of Health and Office of Financial Management.

population size, ranging from 1.8 million people for Seattle-King County to 2,400 people in Garfield County. Fourteen jurisdictions have less than 50,000 people, and ten serve fewer than 25,000 people.

The State Department of Health and Board of Health

The Department of Health is the state's primary public health agency. The agency is headed by the Secretary of Health, who is appointed by the Governor, and is also guided by the state Board of Health. Statute directs the Department to "provide leadership in identifying and resolving threats to the public health" by:

- Working with local health departments and local governments to strengthen the state and local governmental partnership in providing public protection;
- Developing intervention strategies;
- Providing expert advice to the executive and legislative branches of state government;
- Providing active and fair enforcement of rules;
- Working with other federal, state, and local agencies and facilitating their involvement in planning and implementing health preservation measures;
- Providing information to the public; and
- Carrying out other related actions (RCW 43.70.020).

The Department provides some public health services directly. Many of the Department's activities revolve around providing assistance to the local health jurisdictions. The agency is the contracting entity to the local health jurisdictions for a number of different federal and state funds to support a variety of activities. The Department also has broad emergency powers in cases where there may be an immediate threat to public health. These various duties are discussed in more detail below.

The state Board of Health is comprised of the Secretary of Health and nine citizens appointed by the Governor, representing various facets of the public health system. The Board is statutorily directed to "provide a forum for the development of public health policy" (RCW 43.20.050). The Board of Health also has rule-making authority over a number of public health topics – a responsibility it shares with the Department of Health. The Board may advise the Secretary on health issues pertaining to the Department and to the state.

The Department Provides Some Services Directly

Although local health jurisdictions provide most direct public health services, the Department does provide some services and administer some programs directly. These programs or services include the State Health Laboratory; health professions and facility licensing; shellfish, radiation and pesticide programs; large drinking water systems; and wastewater management and large onsite sewage system programs.

The Department Works With Local Jurisdictions

Statute directs the Secretary to "exercise general supervision over the work of all local health departments and establish uniform reporting systems by local health officers to the state

Department of Health" (RCW 43.70.130(6)). As referenced earlier, statute also directs the Department to work with the local jurisdictions to strengthen the state and local public health partnership. In materials prepared for the Joint Select Committee on Public Health Finance, the Department described its roles as follows:

> For most public health services, the local role is the direct delivery of services . . . The state role is to provide expert consultation and technical assistance, coordination across communities, coordination with state and federal funding agencies, and training support (*emphasis in original*).

The Department also acts as the contracting agency to the local jurisdictions for a number of different federal and state funds to support a variety of activities and is responsible for monitoring compliance with these local contracts.

The Department Is Vested with Emergency Powers

Statute vests the Department of Health with broad emergency powers. In some instances, this extends to superseding the authority of a local jurisdiction. The Secretary of Health is to:

- Enforce the public health laws of the state and the rules and regulations promulgated by the Department or the Board of Health in local matters, when in its opinion an emergency exists and the local board of health has failed to act with sufficient promptness or efficiency (RCW 43.70.130(4);
- Have the same authority as local health officers, except that the Secretary shall not exercise such authority unless the local health officer fails or is unable to do so, or when in an emergency the safety of the public health demands it, or by agreement with the local health officer or local board of health (RCW 43.70.130(7).

The Department reports that it has not formally exercised this authority in recent history.

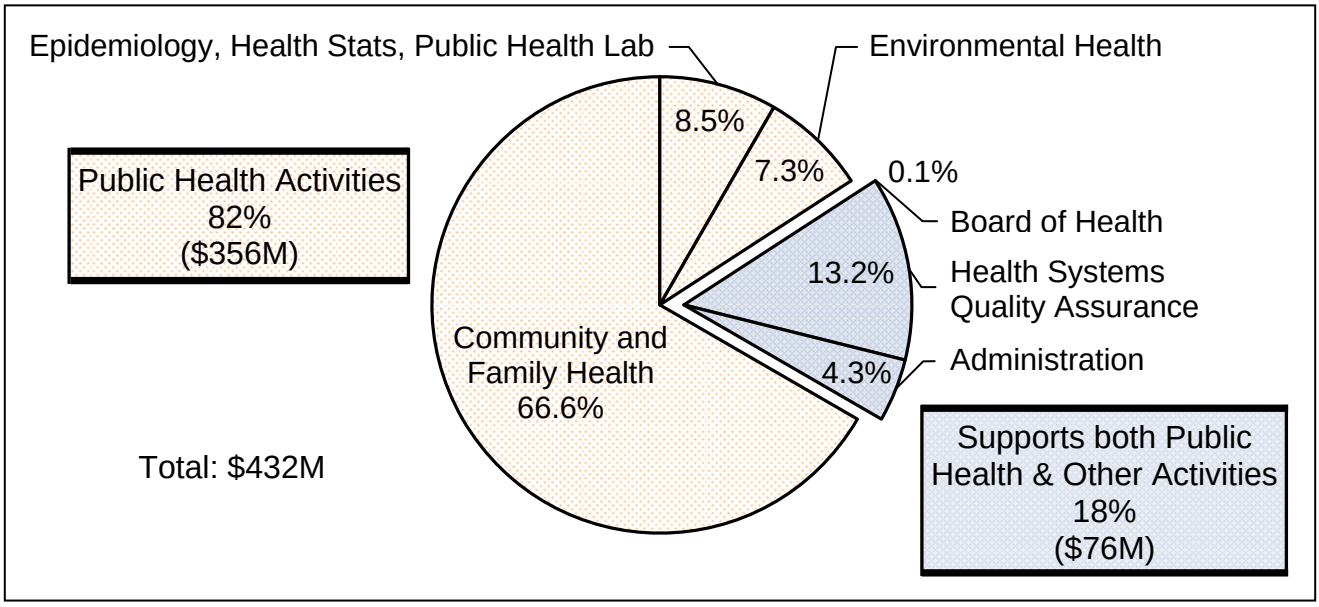
How Is the Public Health System Funded?

The public health system in Washington is funded through a complex mix of federal, state, and local funds, including permits and user fees. Permits and user fees include permits to operate food service establishments or fees paid by homeowners to operate their septic systems. There are no minimum required funding levels at either the state or the local level, and no single major dedicated fund source.

Local health jurisdictions make their own choices about how much to spend on public health. Some local jurisdictions rely more heavily on the local general fund while others rely more on fees. Much of the federal and state funding that goes to the local jurisdictions is "categorical," meaning that the funds can only be used for designated programs or services. Local health jurisdictions receive funds through the Department of Health, the Department of Social and Health Services, and the Department of Ecology.

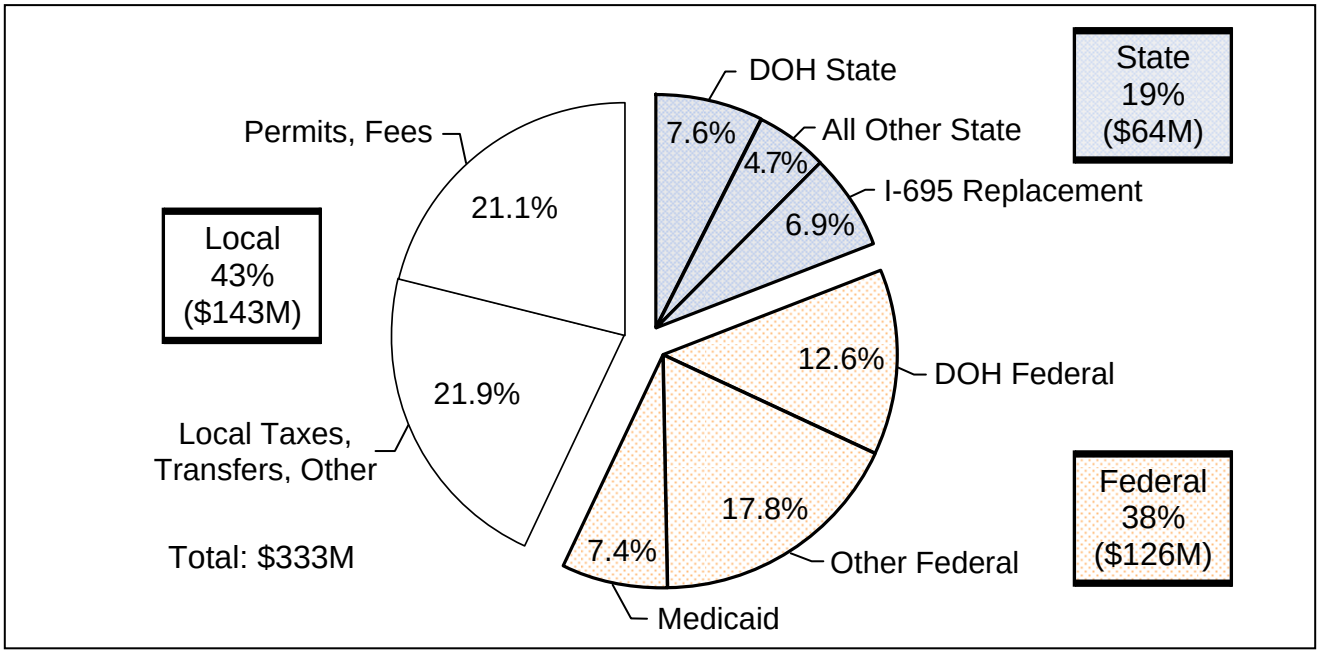
Figures 3 and 4 on the next page provide information about the spending on public health. Figure 3 depicts the Department of Health's operating expenditures for different divisions during calendar year 2005. Three of the divisions provide activities solely related to public health (Community and Family Health; Epidemiology, Health Statistics, and Public Health Lab; and

Figure 3 – The Vast Majority of Department of Health Spending is for Public Health Activities
(Operating Expenditures, on Calendar Year 2005 basis)



Source: Department of Health.

Figure 4 – Public Health Spending at the Local Level Comes from Multiple Sources
(Local Health Jurisdictions Expenditures, Calendar Year 2005)



Source: Department of Health.

Environmental Health). Total spending for these divisions comprise 82 percent of the Department's costs. The remaining three divisions account for 18 percent of costs, and provide resources that support other activities in addition to public health (Health Systems Quality Assurance; Administration; and Board of Health). The Department does not split the costs of these other three divisions between public health or other activities. Therefore, the amount of Department spending in support of public health is in excess of 82 percent of total costs.

Figure 4 shows spending across all of the local health jurisdictions. This figure demonstrates that the local health jurisdictions receive the majority of their funding from other agencies (38 percent federal and 19 percent state). The local health jurisdictions support 43 percent of their spending from local resources, including local taxes, permits, and fees.

How Does the Structure of Washington's Public Health System Compare to Other States?

There are three general types of public health system structures operating in the United States: (1) a decentralized model where, as in Washington, all local jurisdictions are units of local government; (2) a centralized model where local agencies are units of the state public health agency; and (3) a mixed model, where some local jurisdictions are units of local government, and some are units of state government. The decentralized model is the most common, in use in Washington and 29 other states. Eight states use the centralized model, and 12 states have a mixed model.

A literature review and conversations with public health experts provided no direct evidence that any state system structure is superior to another from a perspective of performance effectiveness and service efficiency.

Views on the Operation of the Current System/Structure

As part of this study, we interviewed 33 Directors or Administrators representing each of the state's 35 local health jurisdictions.[1] We designed several of the interview questions to elicit the local jurisdiction's opinion of the Department of Health.

- Overall, 27 local officials report a generally positive view of the Department, compared to four that are more negative and two that are neutral. The Department tends to be viewed more positively by smaller jurisdictions. Three of the four negative views and one of the neutral views come from jurisdictions with populations over 100,000 (of which there are 12 in the state).

- Officials from 18 jurisdictions, particularly the smaller ones, report that they rely substantially on the Department for technical assistance and consultation.

[1] Some local health jurisdictions contract with other local jurisdictions for certain services. Two of our interviews were conducted with individuals who were associated with two jurisdictions each.

A Variation in Structure at the Local Level: Regionalization or "Teaming Up"

State statute permits counties to join together in multi-county public health districts. There are currently three such districts: Benton-Franklin, Chelan-Douglas, and Ferry-Stevens-Pend Oreille.

Several jurisdictions report contracting with other jurisdictions to provide certain services, or informally "teaming up" to provide them. Skamania County contracts all of its public health services out to Clark County. Columbia County contracts with Whitman County to provide some administrative services. Clallam, Jefferson, and Kitsap counties have teamed up to provide a "Regional Duty Officer" – someone who provides a point of contact for 24-hour coverage, that rotates among the three jurisdictions.

In addition, one entire program area – Public Health Emergency Preparedness and Response – has been organized on a regional basis. There are nine regions statewide. One jurisdiction in each region is designated as the lead agency for that region and hosts a Regional Emergency Response Coordinator. The lead agency and coordinator help other jurisdictions within the region develop local preparedness plans and collaborate on a regional plan that ties the local plans together.

The Department of Health indicates that, in past decades, the state encouraged consolidation between counties to achieve a critical mass of population, use of resources, and shared responsibilities. The last multi-county district (Northeast Tri-County) formed in 1977. The Department reports that, for a variety of reasons, a number of the former multi-county health jurisdictions have since separated into individual county health departments. However, the option for multi-county public health districts remains.

Most of those we interviewed made comments indicating that they feel the Department helps them improve their operations.

The Department of Health notes that the foundation of government in Washington is built on strong local control, and that this principle is the basis for the collaborative approach to public health protection. The Department believes the current structure is adequate, given the strong local government base, political environment, financing practices, and history. The Department also notes that:

> In public health, both state and local leaders understand that they cannot carry all the responsibility alone. It is a *system*, drawing on the resources of both local and state government as well as many partners. Public health protection takes the combination of the people closest to the community as well as those who have a statewide perspective and resources, such as the public health lab, food experts, and epidemiologists.[2]

Summary on the Structure of Washington's Public Health System

Washington has a decentralized public health system, with 35 independent local public health jurisdictions operating in Washington. These local jurisdictions are the "action arms" of the state's public health system. The local jurisdictions make choices about which programs to offer and what local investment to make in public health.

[2] Department of Health Response to JLARC Information Request, page 7.

The Department of Health is the state's primary public health agency. The Department provides services and support to the local health jurisdictions. The Department also provides some public health programs and services directly, and the agency has the authority to intervene in local jurisdictions in the case of a public health emergency.

The public health system in Washington is funded through a complex mix of federal, state, and local funds, including permits and user fees. The majority of the funds for the system are federal. Thirty states in the U.S. use this decentralized structure for their public health systems. The majority of local health jurisdiction officials we interviewed express a generally positive view of the state Department of Health.

The History of Washington's Public Health System

The framework for the state's public health system was established in the early years of statehood, and the decentralized structure has remained prominent since then. Key milestones include:

- 1889 The state's Board of Health is established within the State Constitution at statehood as the governing body for all health matters.
- 1893 The Legislature provides for municipal boards of health to enforce the rules of the Board and to assume increased responsibility for problems in their own local areas.
- 1903 The Legislature provides for county boards of health for the same purposes.
- 1921 The first Department of Health is created, lessening the role of the Board.
- 1970 The original Department of Health is merged into the Department of Social and Health Services as the Health Services Division.
- 1989 The Department of Health is re-established as a separate agency.
- 1993 The Department is directed to biennially prepare a Public Health Improvement Plan and, as part of this, to develop public health standards, working in conjunction with the local health jurisdictions and other stakeholders.
- 1995 The Department is directed to identify key health outcomes as part of the Public Health Improvement Plan and to enter into performance-based contracts with the local jurisdictions related to achieving these health outcomes.
- 1996 Implementation of the removal of public health responsibilities from cities is completed, leaving it a county or combined city-county public health system structure at the local level.

CHAPTER THREE – PERFORMANCE REPORTING REQUIREMENTS THROUGH THE PUBLIC HEALTH IMPROVEMENT PLAN

This chapter is organized into four major sections:

- The first section describes legislative actions in 1993 and 1995 to use the biennial Public Health Improvement Plan as a way to convey information about performance of the state's public health system. These statutory provisions have not been revised since their original passage;
- The second section explains how the efforts to implement these statutory provisions have evolved over time and continue to evolve, even as the statutes have not;
- The third section recognizes other public health reporting efforts undertaken by members of the Public Health Improvement Plan Partnership; and
- The chapter concludes with a discussion of whether the performance reporting statutes should be updated.

Section 1 – Legislative Actions in 1993 and 1995

1993 – The Public Health Improvement Plan and Minimum Standards for Public Health Protection

As part of major health care legislation, the 1993 Legislature directed the Department of Health to work in consultation with the local health jurisdictions and a number of other public health agencies and providers to develop the first Public Health Improvement Plan.[3] The legislation directed the Department to present the first plan to the Legislature by December 1994, with an update to follow each biennium.

The legislation directed that the Public Health Improvement Plan include definitions of "**minimum standards** for public health protection through assessment, policy development, and assurances" (RCW 43.70.520(3)). The phrasing of "assessment, policy development, and assurances" reflects three "core functions of public health" as advanced by a major federal health science institution in 1988.[4]

[3] The 1993 statute actually refers to a "public health services improvement plan." Changes to definitions in the 1995 legislation clarified use of the shorter "public health improvement plan."
[4] *The Future of Public Health* by the federal Institute of Medicine, 1988.

In addition to the task of defining these new public health minimum standards, the 1993 legislation requires that the plan include:

- An enumeration of communities not meeting the standards;
- A budget and staffing plan for bringing all communities up to the minimum standards; and
- An analysis of the costs and benefits expected from adopting minimum public health standards for assessment, policy development, and assurances.

The new Public Health Improvement Plan was also to include strategies and a schedule for improving public health programs throughout the state, and a recommended level of dedicated funding for public health services.

1994 – The First Public Health Improvement Plan

The Department completed the first plan on time in December 1994. This first plan included what the plan calls 88 "capacity standards:"

> This plan defines the core function capacity that Washington's local and state public health jurisdictions must have. The 88 capacity standards presented in the plan are the most definitive description we have to date of what well-functioning public health agencies must be able to do. They are a guide for public health jurisdictions as they examine and refine their role in protecting communities (1994 Public Health Improvement Plan, page 3).

The plan goes on to state that "these standards will become the basis for contractual arrangements between state and local jurisdictions" (page 3).

The 1994 plan also includes a six-year implementation strategy, predicated on a large influx of new public health funds. The plan assumes $17.5 million in the first year (1995) and an annual increase by that amount over the next five years ($35 million, $52.5 million, $70 million, $87.5 million, and $104 million) until the annual increase in 2001 is $104 million (page 63).

1995 – A Bill to Implement the Public Health Improvement Plan – Key Health Outcomes

In 1995, the Department of Health was successful with agency request legislation enacted to implement the 1994 plan.[5] The 1995 legislation adds a set of definitions to statute, including these two:

- "Capacity" means actions that public health jurisdictions must do as part of ongoing daily operations to adequately protect and promote health and prevent disease, injury, and premature death (RCW 43.70.575 (1));

[5] In adopting the legislation, "The Legislature declares its intent to implement the recommendations of the Public Health Improvement Plan by initiating a program to provide the public health system with the necessary capacity to improve the health outcomes of the population of Washington State and establishing the methodology by which improvement in the health outcomes and delivery of public health activities will be assessed (ESSB 5253 (1995), Section 1).

- "Health outcomes" means long-term objectives that define optimal, measurable, future levels of health status, maximum acceptable levels of disease, injury, or dysfunction, or prevalence of risk factors in areas such as improving the rate of immunizations for infants and children to 90 percent and controlling and reducing the spread of tuberculosis and are stated in the Public Health Improvement Plan (RCW 43.70.575(4)).

The statute does not list all the specific "health outcomes," but some of the examples it includes are measures that can be classified as *outputs*, such as immunization rates.

The 1995 legislation then goes on to establish the concept of "key health outcomes" and links this to the new statutory concept of public health system capacity. Specifically, the legislation includes direction to the Department of Health to:

- **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;

- Distribute state funds that, in conjunction with local revenues, are intended to improve the capacity of the public health system;

- 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; and

- Biennially, within the Public Health Improvement Plan, evaluate the effectiveness of the public health system; assess the degree to which the public health system is attaining the capacity to improve the status of the public's health, and report progress made by each local health jurisdiction toward improving health outcomes (RCW 43.70.580).

In summary, in 1993 and 1995, the Legislature put into statute requirements to define and measure the performance of the public health system using minimum standards, system capacity, and key health outcomes. These statutes have not been amended since their original enactment.

Section 2 – Evolution in the Implementation of these Statutory Performance Reporting Requirements

As part of this review, we checked on the status of the implementation of the public health performance reporting requirements established by the Legislature in 1993 and 1995. What we found is that implementation of these statutory requirements has been relatively slow, has evolved over time, and continues to evolve. This section looks at these changes over time with regard to the development of the Public Health Improvement Plan itself, the development of and evaluations using the minimum standards, and the development of and assessments using the key health outcomes. The subject of system capacity measures is incorporated into these discussions.

The large-scale infusion of public health funds anticipated in the 1994 plan and the 1995 legislation did not occur. Funding for the state's public health system continues to be an issue of concern for many parties, including legislators; this is what prompted the creation of the Joint Select Committee on Public Health Finance in 2005.

Changes in How the Public Health Improvement Plan is Developed

The development of the first Public Health Improvement Plan in 1994 was a path-breaking effort. At the Department of Health, the effort was lead by new employees, under the guidance of a steering committee. The steering committee membership included a broad range of interests, but only two members came from the local public health jurisdictions. The Department reports that there was significant tension within the local public health jurisdictions about development of the Plan because most steering committee members had limited knowledge of direct delivery of local public health services.

Over time, and within the framework of the Plans, the Department of Health, the local health jurisdictions, and others have formed what they now refer to as the Public Health Improvement Planning Partnership, with much more involvement from representatives of the local health jurisdictions. Partnership members have organized themselves into committees covering performance management (standards), key health indicators, workforce development, information technology, and communications. The committees develop two-year work plans, and they convey their progress on these work plans and their future work plans as part of the biennial Public Health Improvement Plans.

Development of and Assessments Using Minimum Public Health Standards

The directive to define minimum public health standards came from the Legislature in 1993. There was an effort as part of the 1994 plan to develop the 88 "capacity standards." A whole new effort to develop a set of minimum standards began in 1998. The Department orchestrated a baseline assessment of state and local public health agencies against these revised standards in 2002 and a full assessment in 2005. Figure 5 on the next page provides a brief timeline for this effort and shows changes in the standards themselves and the assessments over time.

The minimum standards have been – by design – primarily process-oriented, representing "what every public health agency in Washington should be able to do regardless of size or location."[6] For example, one standard states that the public health agencies should maintain a process for identifying, monitoring, and reporting on emerging threats to the public's health, while another standard indicates that public health programs should have specific goals, objectives, and performance measures along with established mechanisms for tracking, reporting, and using the results.

[6] *2007 Standards for Public Health in Washington*, page 3.

Figure 5 – Minimum Public Health Standards and Evaluations Using Those Standards Have Changed Over Time

Timeframe	Development of Standards	Evaluations Using Standards
1994	First development of 88 "capacity standards." The Department notes that, while this was a pioneering effort, the "capacity standards" were not designed with performance measurement in mind.	
1996		The Department reports that there was some effort for self-reporting from state and local public health agencies using the capacity standards.
1998 - 2000	The Department and its partners develop a plan to fulfill the statutory requirement to develop "minimum standards." The new standards are structured around five topics (Communicable Disease, Health Assessment, Environmental Health, Health Promotion/Prevention, and Access to Care). The group also develops measures for state and local agencies to assess the extent to which the agencies meet the standards.	The new measurement system is field-tested in 2000. Aggregate results of the field test are published. The results for the field test are not released by county other than to that county.
2001 - 2002	There is some slight revision to the standards. There are 23 standards, still arranged in five topical areas (Understanding key health issues; Protecting people from disease; Assuring a safe and healthy environment; Promoting health living; and Helping people get the services they need).	The first official assessment is launched to collect baseline information on performance using the minimum standards. Aggregate results of the baseline findings are published. County-specific information is available by request.
2005		Assessment against the minimum standards, with comparisons possible against the 2002 baseline measurement. Information in aggregate and by county is published and available on the Department website.
2006	The Partnership revises the minimum standards from 23 to 12. The Department indicates that this and future changes to the standards show an intent to move beyond demonstrating basic processes and capacity to adoption of more quantifiable, results-based measures.	
2008		An assessment is planned using the revised (12) minimum standards.

Source: JLARC compilation of Department of Health information.

For each standard, the Partnership develops measures that can be used to assess whether the standard is being met. There is one set of measures for agencies at the state level and a separate set used in assessment of the local health jurisdictions. Figure 6 provides an example of the state and local measures for one of the new public health standards.

Figure 6 – An Example of a 2006 Revised Public Health Standard and the Corresponding Local and State Measures

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.	
Local Health Jurisdiction (LHJ) Measures	Dept of Health/State Board of Health Measures
5.1L. A primary contact person(s) for health risk reporting purposes is clearly identified in emergent communications to health providers and appropriate public safety officials.	5.1S Written procedures are maintained and disseminated for how to obtain consultation and technical assistance regarding emergency preparedness for environmental health risks, natural disasters, or other threats to the public's health. Written documentation demonstrates that consultation and technical assistance have been provided.
5.2L. Environmental health risks, communicable disease outbreaks, and other public health emergencies are included in the local public health emergency preparedness and response plan (EPRP). The EPRP describes the specific roles and responsibilities for LHJ programs/staff regarding local response and management of disease outbreaks, environmental health risks, natural disasters, or other threats to the public's health. The LHJ EPRP includes a section that describes processes for exercising the plan, including after-action review and revisions of the plan. Drills, after-action reviews, and revisions, if necessary, are documented.	5.2S. Environmental health risks, communicable disease outbreaks, and other public health emergencies are included in the DOH emergency preparedness and response plan (EPRP). The EPRP describes the specific roles and responsibilities for DOH programs/staff regarding local response and management of disease outbreaks, environmental health risks, natural disasters, or other threats to the public's health. The DOH EPRP includes a section that describes processes for exercising the plan, including after-action review and revisions of the plan. Drills, after-action reviews, and revisions, if necessary, are documented.
5.3L. The LHJ leads community-level public health emergency planning, exercises, and response/ restoration activities and fully participates in planning, exercises, and response activities for other emergencies in the community that have public health implications.	5.3S. DOH leads state-level public health emergency planning, exercises, and response/restoration activities and fully participates in planning, exercises, and response activities for other emergencies in the state that have public health implications.
5.4L. Public health services that are essential for the public to access in different types of emergencies are identified. Public education and outreach includes information on how to access these essential services.	5.4S. Public health services that are essential for the public to access in different types of emergencies are identified. Public education and outreach includes information on how to access these essential services.
5.5L. New employees are oriented to the emergency preparedness and response plan, and the EPRP is reviewed annually with all employees.	5.5S. New employees are oriented to the emergency preparedness and response plan, and the EPRP is reviewed annually with all employees.

Source: January 2007 Standards for Public Health in Washington State, page 12.

The state and local public health agencies underwent a baseline assessment against the public health standards in 2002, then a full assessment in 2005. Agencies use a self-assessment tool to rate and document their performance. This is followed with a review by an outside team of consultants, with an emphasis on the degree to which the state or local agency demonstrates performance for each measure. Agencies are scored on whether they "demonstrate," "partially demonstrate," or "do not demonstrate" performance for each measure. These scores are used to estimate the *capacity* of the state and local parts of the public health system to meet the minimum standards. Figure 7 provides a summary of the results from the 2005 assessment.

Figure 7 – Results From the 2005 Assessment – Minimum Public Health Standards

Standards in 2005	% Fully Meeting the Standard	
	Average Scores for Dept of Health	Average Scores for 35 Local Health Jurisdictions
Communicable Disease Standards		
• 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%
Promoting Healthy Living		
• 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%
Assuring a Safe, Healthy Environment		
• 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%
Understanding Health Issues		
• 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%
Helping People Get the Services They Need		
• 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 and reported	31%	25%

Source: 2006 Public Health Improvement Plan, pages 18 – 28.

The state and local public health agencies are not all meeting the minimum public health standards. The Partnership members are quite forthright in acknowledging this level of performance. They believe that agencies are unlikely to all be able to meet the standards unless additional resources are devoted to the public health system.[7]

Appendix 3 lists the new public health standards. An assessment using these new standards will take place in 2008. The Department indicates the standards and measures may continue to evolve as the Partnership tries to move beyond demonstrating basic processes and capacity toward more quantifiable, results-based measures.

The 1993 legislation also called for the Department of Health to develop a budget and staffing plan for bringing communities up to the minimum standards, and to conduct an analysis of costs and benefits expected from adopting minimum public health standards. The Department has conducted analyses periodically on the cost to have all local health jurisdictions meet the minimum standards; the estimate for 2006 is that an additional $300 million per year is needed. The Department has not conducted a specific cost/benefit analysis, but has instead used examples to describe the benefits of having the minimum public health standards.

Development of and Evaluations Using Key Health Outcomes

The 1995 legislation establishes in statute the concept of performance reporting related to *key health outcomes*. While the minimum public health standards seek to identify what every public health agency should be able to do, the work on the health outcomes or indicators is tied more directly to public health conditions such as whether we have clean drinking water and to what extent we have illnesses that could be prevented by immunization.

Figure 8 on the next page provides a timeline for the implementation of the development of and assessments using key health outcomes or indicators. Similar to the public health standards, there was some initial work right after the measure was enacted. However, major work did not begin until 2000, and the first assessment using key health indicators was published in 2005 in the *Report Card on Health in Washington*. At a statewide level, Washington's health conditions receive grades ranging from A to F depending on the Report Card category. The Report Card results may be found in Appendix 4.

Many of the indicators published in the 2005 state Report Card use state-based data, which does not allow the Department to report on the progress of each local health jurisdiction in improving health outcomes as required in statute. The Partnership has now developed a set of 32 Local Public Health Indicators, which will allow for health indicator reporting at the local jurisdiction level. The new Local Public Health Indicators are presented in Figure 9 on page 22. The Department reports that the first results from this new tool will be available in mid-2007.

[7] The 2006 Public Health Improvement Plan provides an example: "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" (page 15).

Figure 8 – Key Health Outcomes/Indicators Have Also Changed Over Time

Timeframe	Development of Key Health Outcomes	Evaluations Using Indicators
1995-1997	The Department reports that local health jurisdictions were required by contract to conduct community health assessments. The Department also reports that local jurisdictions were allowed to decide which variables were included in their local reports, so the reports were allowed to vary among jurisdictions.	The Department reports that the contract included an obligation to publish the community health assessment, which included local health data.
2000	A Key Health Indicators Committee is formed as part of the Partnership, and the Department contracts with a consultant to help develop a list of key health outcomes. The Department reports that the group wanted indicators based on *determinants* of health rather than a list of diseases and rates.	
2001-2004	The group finalizes a list of health indicators, selects data sources for the indicators, and develops a way to "grade" health outcomes based on trends, disparities, and comparisons to other states.	
2005		The Department and Partnership publish the first *Report Card on Health in Washington*. Much of the information is on a statewide basis, with information for many of the indicators not available on a county or local jurisdiction level.
2004-2006	The group develops a set of 32 Local Public Health Indicators that can be assessed on a county-level basis.	
2007		The Department reports that the results from the first assessment using the new Local Public Health Indicators will be available in mid-2007.

Source: JLARC compilation of Department of Health information.

Figure 9 – Local Public Health Indicators

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

Source: 2006 Public Health Improvement Plan, page 49.

In addition to the assignment of identifying health outcomes and reporting progress by local jurisdictions in improving these outcomes, the 1995 legislation includes additional assignments for the Department of Health. One of the assignments is to distribute state funds to improve system capacity; however, the anticipated large influx of public health funds for this purpose did not materialize.

A more difficult task to assess is compliance with the requirement for the Department to enter into performance-based contracts with the local health jurisdictions. In our review of these contracts, we did not find evidence of traditional performance-based contracting. However, the statutory requirement is different than many traditional definitions of performance-based contracting. Instead, the current statutory language refers to performance-based contracting based on attaining system capacity, with the contracts identifying progress toward achieving health outcomes. As discussed earlier, "health outcomes" are defined in statute to include what would often be considered health *output* measures such as immunization rates. Our review found that the majority of contracts did include some kind of health-related output statistics. The Department confirms that its contracts include specific deliverables, which may include reports on capacity, process, or outcomes. However, the contracts the Department has developed do not universally link performance, "capacity," and "health outcomes" measures in response to statutory requirements.

Finally, the 1995 legislation calls for the Department to assess the capacity of the public health system and to evaluate the effectiveness of the system. In terms of assessing *capacity*, the Department relies on the assessments using the minimum public health standards and the estimate of the cost to bring the public health agencies up to these minimum standards. The Department reports that its evaluation of the public health system is addressed broadly in each biennial Public Health Improvement Plan. The plans and other publications do report information on the assessments against the standards and now the health indicator information.

Section 3 – Additional Reporting on Washington's Public Health System

This chapter has focused on the performance reporting of the public health system connected to the statutory provisions the Legislature installed in 1993 and 1995. However, this information is not the only information available on the status of public health in Washington. Examples from participants in the Public Health Improvement Planning Partnership include:

- The Department of Health publishes *The Health of Washington State*, which includes information and a summary of the literature on 77 public health issues. This report was first issued in 2002, and the Department anticipates release of a revised version in 2007;
- The Washington Health Foundation publishes a comparison of Washington with other states using a set of 18 public health indicators; and
- A number of materials were assembled for the Joint Select Committee on Public Health Finance, including a *Statewide Priorities for Action* by the Washington State Association of Local Public Health Officials.

In addition, local public health officials assemble information pertinent to their local jurisdictions for their local health boards and other interested parties. Information about the status of public health in Washington is available from a variety of sources.

Section 4 – A Time to Revisit the Performance Reporting Statutes?

Public health officials, the Legislature, and other interested parties will continue to be interested in information about the state's public health system, including information on the system's capacity and on specific health factors.

As described above, we have completed a review of how the Department of Health has complied with performance reporting statutes, and we found that the Department is meeting most statutory provisions, with an exception of partial compliance with performance-based contracting requirements. Normally this would complete a JLARC review of statutory compliance. In this situation, however, as described in this chapter, the performance assessments using the standards and health outcomes have been evolving over the course of 14 years while the statutes remain the same. For example,

- The statute from 1993 calling for the definition of minimum standards draws on language from a 1988 report by the federal Institute of Medicine. The Partnership found that it was difficult to link the Institute's "core functions of public health" – assessment, policy development, and assurance – to specific actions and metrics. Therefore, the Partnership has moved beyond them in the development of the standards it is currently using;

- The Partnership's 2006 work plan includes a merging of some work of the committees on Performance Management (Standards) and Key Health Indicators to evaluate health indicators that could be used in conjunction with standards;

- At the time of the drafting of the statutory language in 1993 and 1995, the public health community assumed a large influx of new state money for public health, which did not occur; and

- Agencies in Washington have developed more expertise with concepts such as outcomes, outputs, and performance contracting since the passage of the 1995 legislation, for example, through the Government Management Accountability and Performance (GMAP) effort.

Additionally, the Legislature passed Engrossed Second Substitute Senate Bill 5930, which requires new performance reporting requirements for core public health functions as recommended by the Joint Select Committee on Public Health Finance.

As a result of these many changes, public health officials and the Legislature may benefit from the Department and its partners revisiting the language from the 1993 and 1995 statutes and making suggestions to update the language to the practices of the current time and situation while maintaining the requirements to provide important performance information.

Recommendation 1:

The Department of Health should review the statutory language used to describe the performance reporting requirements for the public health system and make suggestions to update the language in light of current practices, while maintaining requirements to provide important performance information. As part of its review, the Department should identify appropriate language to link contracted funds with performance. The Department should deliver its suggested changes to the language in the public health performance reporting statutes in a report to the Legislature by January 2008.

CHAPTER FOUR – CONSISTENCY IN LOCAL PUBLIC HEALTH SERVICE DELIVERY

Local health jurisdictions have the responsibility for implementing a number of state and local requirements to keep their local citizens safe, ranging from food and drinking water safety to the control and prevention of dangerous diseases. In meeting these responsibilities, local jurisdictions tailor their actions to the communities they serve; the local jurisdiction decides which programs to invest in and at what level of funding. Given this local autonomy, one would expect there to be variation in public health service delivery from one jurisdiction to another.

It would be helpful for public health officials, the Legislature, and others to know what choices these local boards of health are making and what impact their choices have on public health at the local level. Unfortunately, standardized information is not currently available to answer these questions. This chapter provides a snapshot of the information that is available about local health jurisdictions, namely information on local public health expenditures and performance in meeting the state's minimum public health standards. The chapter then discusses efforts underway to provide additional public health information at the local jurisdiction level in the future.

> *Public health agencies are a lot like fire departments. They teach and practice prevention at the same time they maintain readiness to take on emergencies. They are most appreciated when they respond to emergencies. They are most successful – and least noticed – when their prevention measures work the best.*
>
> ~ The first Public Health Improvement Plan, 1994

Public Health Expenditures Vary By Local Jurisdiction

Given their authority to choose programs and investment levels, it comes as no surprise that public health expenditures vary from one local jurisdiction to another. Figure 10 shows total and per capita public health expenditures by jurisdiction for 2005. Figures 11 and 12 illustrate this same information using categories of expenditure levels, for total and per capita expenditures respectively. Per capita expenditures are calculated by dividing total expenditures by the 2005 population level in each local jurisdiction.

Total public health expenditures are highest in the two jurisdictions with the highest population levels (Seattle-King County and Tacoma-Pierce County). This same population correlation does not hold true, however, for per capita expenditures. Here the three local health jurisdictions with the highest per capita public health spending are counties with lower population rates. The highest per capita spending for 2005 is in San Juan County at $142 per person, followed by Wahkiakum County at $115 per person and Garfield County at $109 per person. Garfield County and Columbia County have the lowest levels of total expenditures, while Cowlitz County and Yakima County expenditures are the lowest per capita. The Department notes that there may be unique circumstances affecting these local health jurisdiction expenditure levels; for example, a local hospital may be providing a service in one area that is provided by the local health agencies in other areas.

Figure 10 – Total and Per Capita Expenditures on Public Health Services Vary by Local Jurisdiction (Total Expenditures from All Fund Sources, 2005)

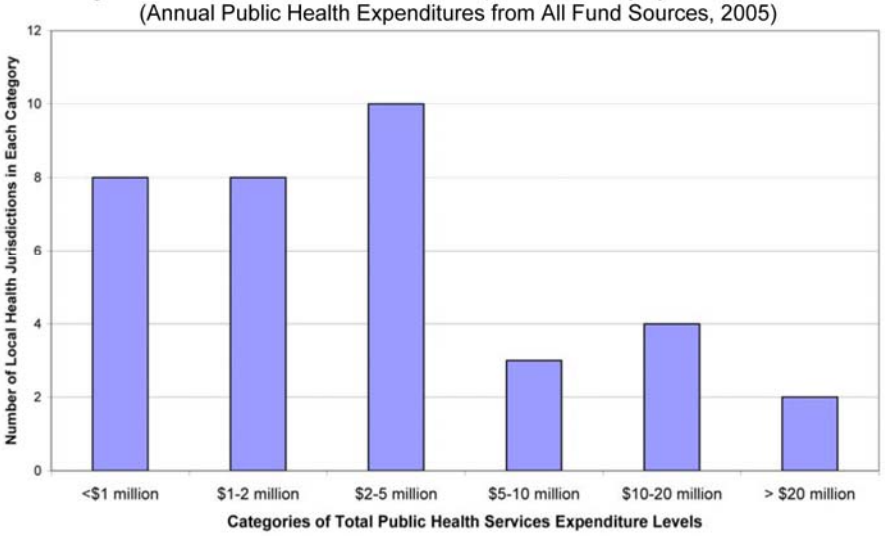
Local Jurisdiction	Total Expenditures	2005 Population	Per Capita Expenditures
Adams	$651,246	17,000	$38.31
Asotin	734,357	20,900	35.14
Benton-Franklin	7,128,985	218,600	32.61
Chelan-Douglas	4,318,316	103,900	41.56
Clallam	1,713,559	66,800	25.65
Clark	12,339,646	391,500	31.52
Columbia	294,024	4,100	71.71
Cowlitz	1,805,367	95,900	18.83
Garfield	263,466	2,400	109.78
Grant	1,737,647	79,100	21.97
Gray's Harbor	3,080,240	69,800	44.13
Island	3,475,411	76,000	45.73
Jefferson	2,457,612	27,600	89.04
Kitsap	11,641,260	240,400	48.42
Kittitas	1,545,251	36,630	42.19
Klickitat	1,326,007	19,500	68.00
Lewis	2,463,682	71,600	34.41
Lincoln	598,660	10,100	59.27

Local Jurisdiction	Total Expenditures	2005 Population	Per Capita Expenditures
Mason	$2,359,710	51,900	$45.47
NE Tri-County	2,286,228	60,800	37.60
Okanogan	1,374,208	39,600	34.70
Pacific	747,408	21,300	35.09
San Juan	2,204,094	15,500	142.20
Seattle-King	162,446,862	1,808,300	89.83
Skagit	3,585,569	110,900	32.33
Skamania	494,213	10,300	47.98
Snohomish	18,321,128	655,800	27.94
Spokane	19,712,834	436,300	45.18
Tacoma-Pierce	29,883,600	755,900	39.53
Thurston	9,158,244	224,100	40.87
Wahkiakum	448,586	3,900	115.02
Walla Walla	1,651,159	57,500	28.72
Whatcom	9,633,917	180,800	53.28
Whitman	1,232,259	42,400	29.06
Yakima	4,524,878	229,300	19.73

A Cautionary Note on BARS Financial Data and Public Health Program Information

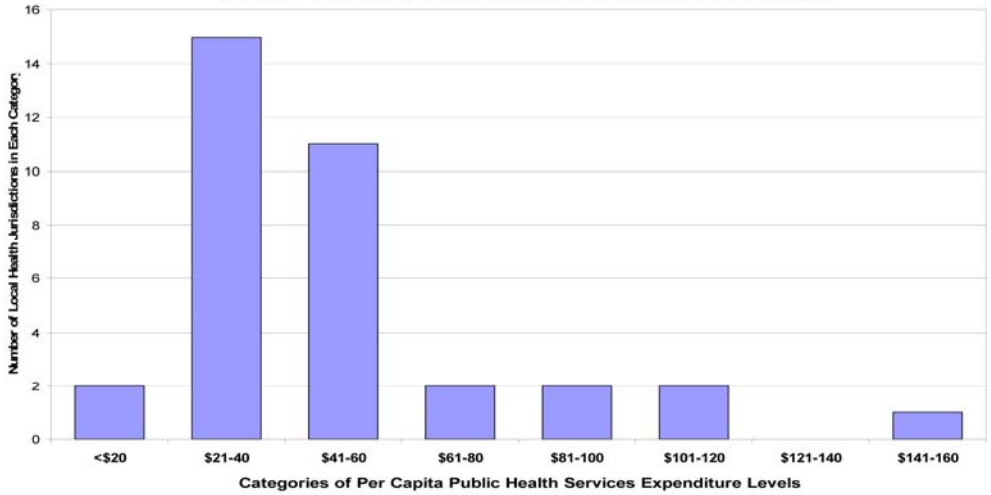
The Department of Health publishes an expenditure report each year using financial expenditure information that local jurisdictions have provided through the state's Budget Accounting and Reporting System (BARS). The reporting mechanism used is a series of codes that could be mistaken for public health programs such as "Maternal/Infant/Child" and "Family Planning." The Department notes that BARS is an accounting tool, and that BARS codes **do not** equate to public health programs. The Department has provided JLARC with examples of where a program could be legitimately reported by local jurisdictions under different codes and where expenditure information under one code could represent very different public health programs. Figure 10 uses total expenditures rather than comparing local jurisdictions using individual BARS codes. Practitioners should avoid making assumptions and comparisons about individual local health jurisdiction programs and services based on the BARS coding system.

Figure 11– Total Public Health Services Expenditures Vary by Local Jurisdiction
(Annual Public Health Expenditures from All Fund Sources, 2005)



< $1 million	$1-2 million	$2-5 million	$5-10 million	$10-20 million	>$20 million
Adams	Clallam	Chelan-Douglas	Benton-Franklin	Clark	Seattle-King
Asotin	Cowlitz	Grays Harbor	Thurston	Kitsap	Tacoma-Pierce
Columbia	Grant	Island	Whatcom	Snohomish	
Garfield	Kittitas	Jefferson		Spokane	
Lincoln	Klickitat	Lewis			
Pacific	Okanogan	Mason			
Skamania	Walla Walla	NE Tri-County			
Wahkiakum	Whitman	San Juan			
		Skagit			
		Yakima			

Figure 12 – Per Capita Public Health Service Expenditures Vary by Local Jurisdiction
(Annual Public Health Expenditures from All Fund Sources, 2005)



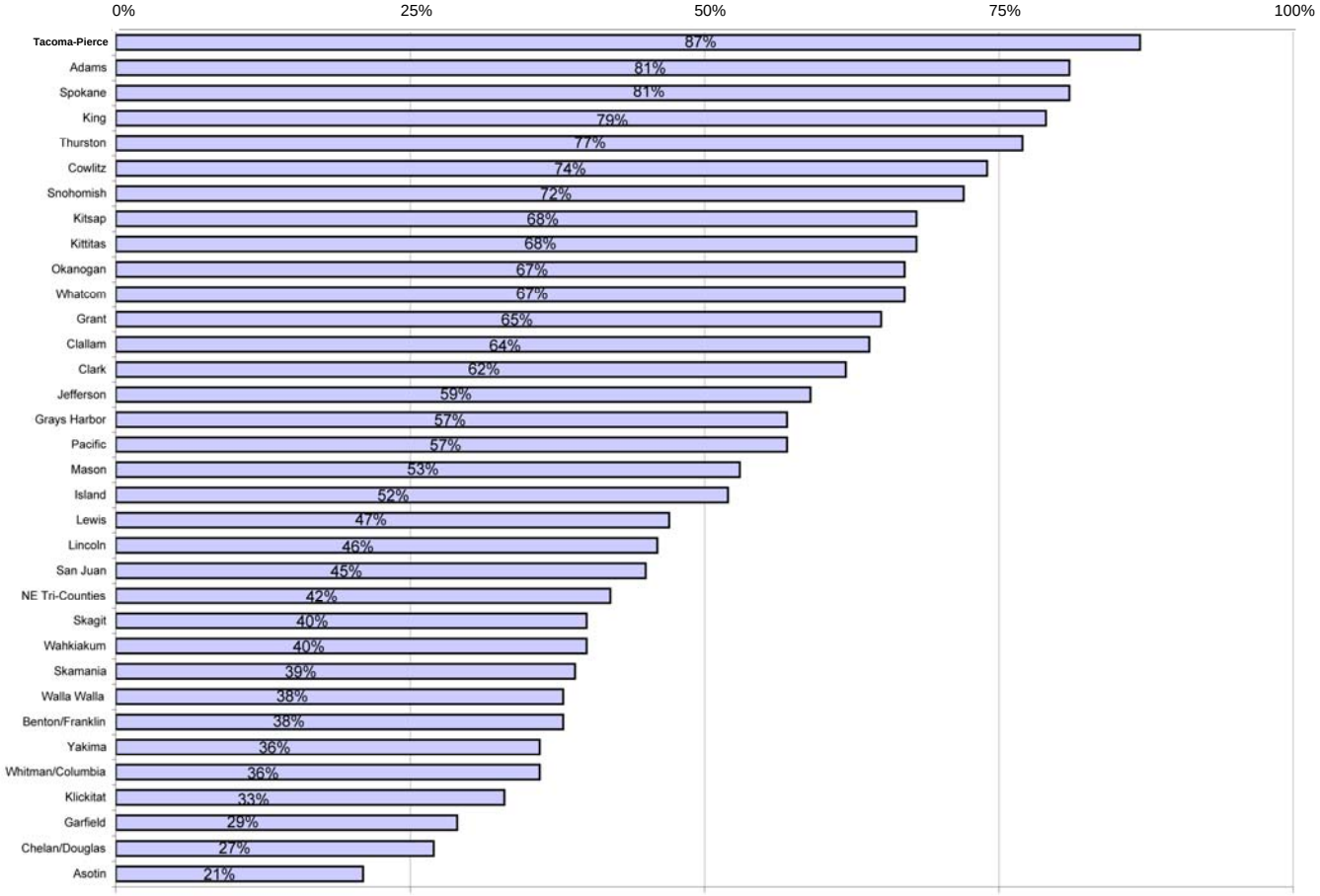
< $20	$21 – 40	$41 – 60	$61 – 80	$81 – 100	$101 - 120	$121 - 140	$141 - 160
Cowlitz	Adams	Chelan/Douglas	Klickitat	Jefferson	Garfield		San Juan
Yakima	Asotin	Grays Harbor	Columbia	Seattle-King	Wahkiakum		
	Benton/Franklin	Island					
	Clallam	Kitsap					
	Clark	Kittitas					
	Grant	Lincoln					
	Lewis	Mason					
	NE Tri -County	Skamania					
	Okanogan	Spokane					
	Pacific	Thurston					
	Skagit	Whatcom					
	Snohomish						
	Tacoma/Pierce						
	Walla Walla						
	Whitman						

Local Health Jurisdiction Performance on the Minimum Public Health Standards

Chapter 3 includes information on the development of the statutorily-required public health standards and the assessment of state and local agencies with relation to these standards in 2005. Recall that the standards represent what every health department should be able to do, regardless of size or location. Each local health jurisdiction is scored on a set of measures under each standard. The options for scoring results include demonstrating, partially demonstrating, or not demonstrating performance against each measure.

Figure 13 below shows the results of the local agency component of the 2005 assessment against the standards, by local health jurisdiction. The number on the individual bars shows the percent of measures where the local jurisdiction was found to demonstrate compliance with the measure. As with the expenditure information, there is wide variation among jurisdictions. The Tacoma-Pierce County jurisdiction has the highest rate of demonstrating compliance with the standards, at 87 percent. Asotin County has the lowest ranking of the local jurisdictions, and 15 of the local health jurisdictions have a full compliance rate of less than 50 percent.

Figure 13 – Rate of Demonstrating Performance with the State Public Health Standards Among Local Health Jurisdictions – 2005 Assessment Results



Source: JLARC, based on Department of Health data.

The detailed analysis of each local jurisdiction's performance against each measure allows an interested party to see the strengths and weaknesses for a given local area.

An analysis of possible correlation between a local jurisdiction's per capita spending levels and its performance against the minimum public health standards reveals no clear relationship between the two. Local jurisdictions in Cowlitz and Snohomish counties, for example, demonstrated relatively higher performance against the standards while registering in the lower tiers of per capita spending. Conversely, Wahkiakum and Garfield counties are examples of jurisdictions with relatively lower performance against the standards but registering in an upper tier of per capita spending.

Health Indicators at the Local Jurisdiction Level

Chapter 3 also discusses the evolution in development of and reporting on key health indicators in the state. The Department of Health and its partners recently completed work on a set of 32 Local Public Health Indicators (Figure 9 on page 24). The assessment using this new set of indicators will provide comparable health indicator information by local jurisdiction. The first results using the new local health indicators are expected in mid-2007.

A New Effort to Collect Information on Local Public Health Services

The 2006 Public Health Improvement Plan includes a recommendation to design and complete an inventory of public health services that would document both the type and the amount of services provided in each local jurisdiction. This could be a challenging effort; the Department notes that currently no two local health jurisdictions track the same information in the same way except for what is required by the Department or other state agency contracts. The plan does not provide an expected completion date for this new effort. Such an inventory, especially when used in concert with the other information identified in this chapter, would facilitate a review of the consistency of public health service delivery among the local health jurisdictions.

Summary on Consistency in Local Public Health Service Delivery

Given the structure of Washington' public health system and the authority of individual local health boards to choose their levels of program participation and investment, one would expect variation in public health service delivery from one local jurisdiction to another. Information is not currently available to paint a comprehensive picture of the consistency of service delivery among the local jurisdictions. Available information does show significant variation in public health expenditures and in ability to meet the state's public health standards. Information on local public health indicators is expected later this year, and the Department and its partners intend to develop an inventory that will show public health services by local health jurisdiction.

CHAPTER 5 – SUMMARY AND RECOMMENDATION

The operation of the state's public health system touches the people of Washington in many different ways. The Joint Legislative Audit and Review Committee's review of the public health system covers three areas: (1) the structure of Washington's system; (2) the statutory reporting requirements on system performance and how those requirements are being implemented; and (3) information available on the consistency of public health provision at the local level.

Structure of Washington's Public Health System

Washington has a decentralized public health system rather than a state-run or state-directed system. There are 35 local health jurisdictions, each with a local governing board of health. Most are organized along county boundaries, though there are three multi-county jurisdictions. Local health jurisdictions act as the "action arms" of the public health system, providing the bulk of direct services. The local boards of health have discretion in how best to meet their public health obligations, deciding which public health programs to invest in and at what level of investment.

The state Department of Health is the state's primary public health agency. The Department provides some public health services directly, for example, through the state's public health laboratory. The Department works with the local jurisdictions, providing services through consultation, technical assistance, training, and other avenues. The Department acts as the contracting agency to the local jurisdictions for a number of different state and federal funds to support a variety of activities. The Department also has broad emergency powers to intervene at the local level in emergency situations; however, the agency has not exercised this authority in recent history.

Washington's public health system is funded through a complex mix of federal, state, and local funds, including permits and user fees. Many of the state and federal funds may only be used for specific programs or services.

Washington shares this decentralized public health system structure with 29 other states. The remaining states have systems that are either state-administered (8 states) or have a blend of state and local authority over public health (12 states).

Assessing System Performance

The Legislature established a structure for public health system performance reporting with legislation in 1993 and 1995. The statutory reporting requirements revolve around **minimum public health standards**, **system capacity**, and **key health outcomes**. The minimum public health standards describe what state and local public health agencies in Washington should be able to do, regardless of size or location; for example, have a process to identify, monitor, and report on emerging threats to the public's health. The Department of Health combines the results from assessments against the minimum standards with an analysis of the amount of resources needed to bring all agencies up to these standards as a way to gauge system capacity. Key health outcomes or indicators report information tied more directly to public health conditions such as whether people have clean drinking water and the percent of women receiving early prenatal care.

The implementation of the 1993 and 1995 statutory reporting requirements has been slow, but systems are now in place that reflect the statutory requirements. A baseline assessment of state and local public health agencies against a set of minimum public health standards occurred in 2002, with a full assessment in 2005. That assessment shows that the state and local agencies are not meeting the minimum public health standards. Work on development of the set of standards has continued, and an assessment against a revised set of standards is scheduled for 2008. The Department of Health has also developed an estimate of the cost to bring all communities up to the minimum standards; the Department's estimate in 2006 is that an additional $300 million per year would be necessary to do so.

The other major reporting system established in statute is based on key health outcomes or indicators. The Department of Health and its public health partners finalized a set of health indicators in 2004 and published a first *Report Card on Health in Washington* in 2005. On a statewide basis, Washington received grades between A and F depending on the report card category. This first report card uses many statewide health indicators and so does not allow reporting at the local jurisdiction level. The Department and its partners have, however, recently developed a set of 32 Local Public Health Indicators that will allow for health indicator reporting at the local jurisdiction level. The first reporting using the Local Public Health Indicators is due in mid-2007.

One area where our review indicates the Department of Health is not fully complying with statute is with regard to a requirement for performance-based contracts that link to capacity building and health outcomes.

Consistency in Local Public Health Service Delivery

Given the structure of Washington's public health system and the authority of individual local health boards to choose their levels of program participation and funding, one would expect variation in public health service delivery from one local jurisdiction to another. Information is not currently available to paint a comprehensive picture of the consistency of service delivery among the local jurisdictions. The information that is available shows significant variation in public health expenditures and it meeting the state's minimum public health standards. Information on local public health indicators is expected later this year, and the Department of Health and its partners intend to develop an inventory that will show public health services by local health jurisdiction.

Study Recommendation

This report traces the evolution in the implementation of the minimum public health standards and key health outcomes. We have reviewed how the Department of Health has complied with the performance reporting statutes, and we found that the Department is meeting most statutory provisions, with an exception of partial compliance with performance-based contracting requirements.

Chapter 3 provides some examples of how the context around using these performance reporting tools has changed while the statutes have remained the same. There may also be new performance reporting requirements depending on the Legislature's response to the proposals by the Joint Select Committee on Public Health Finance. Public health officials and the Legislature may benefit from the Department and its partners revisiting the language from the 1993 and 1995

statutes and making suggestions to update the language to the practices of the current time and situation.

Recommendation 1:

The Department of Health should review the statutory language used to describe the performance reporting requirements for the public health system and make suggestions to update the language in light of current practices, while maintaining requirements to provide important performance information. As part of its review, the Department should identify appropriate language to link contracted funds with performance. The Department should deliver its suggested changes to the language in the public health performance reporting statutes in a report to the Legislature by January 2008.

Legislation Required:	After its review, the Department may be suggesting statutory changes.
Fiscal Impact:	JLARC assumes the review can be completed with existing resources.
Completion Date:	January 2008

APPENDIX 1 – SCOPE AND OBJECTIVES

Performance Audit of the Department of Health's Public Health Mission

SCOPE AND OBJECTIVES

MARCH 2006

STATE OF WASHINGTON
JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE

STUDY TEAM

ROBERT KRELL

LEGISLATIVE AUDITOR

RUTA FANNING

Joint Legislative Audit & Review Committee
506 16th Avenue SE
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BACKGROUND

State statute defines "public health," in part, as "activities that society does collectively to assure the conditions in which people can be healthy."[8] In practical terms, public health encompasses an extremely broad range of activities which, in Washington, have been grouped into five functional areas:

- ✓ Protecting people from disease (including communicable diseases such as tuberculosis, HIV/AIDS, West Nile Virus, pandemic flu);
- ✓ Assuring a safe, healthy environment (including drinking water quality, solid and hazardous waste, air quality monitoring, food safety);
- ✓ Prevention and health promotion (such as cancer prevention and control, cardiovascular risk reduction, family and social health issues);
- ✓ Access to health services (such as family planning and oral health care); and
- ✓ Understanding health issues (including documenting community health issues, vital records, epidemiology).

The Department of Health is the state's primary public health agency, but the state's overall public health *system* extends far beyond just the Department. The system is a partnership between state and local entities, with authority and responsibility primarily shared between the Department, the State Board of Health, and 35 *independent* local health jurisdictions.

In fiscal year 2004, combined state and local spending for public health totaled $589 million, with slightly more than half being spent at the local level. Funding for public health services derives from federal, state, and local sources.

STUDY SCOPE

This performance audit will examine various facets of the state's public health system. It will primarily focus on reviewing the Department of Health's role in preserving public health throughout the state by examining its activities for certain public health-related responsibilities, and reviewing its relationship with the state's local health jurisdictions.

STUDY OBJECTIVES

1) Review and describe Washington's public health system, including:
   a) The types of services provided;
   b) Its statutory and organizational structure, including the role, authority, and responsibilities of the state Department of Health, the state Board of Health, and the state's 35 independent local health jurisdictions;
   c) How the system is funded;
   d) How similar Washington's public health system is to systems in other states, and;
   e) How Washington compares to other states on various public health indicators.

[8] RCW 43.70.575

STUDY OBJECTIVES – cont.

2) Examine and assess the Department of Health's relationship with the state's local health jurisdictions, including:
   a) The extent to which the Department contributes to the efficiency and effectiveness of the local health jurisdictions by providing funding, direct services, technical assistance, coordination, and policy leadership;
   b) The extent to which the Department is able to effectively address statewide public health concerns by working through the local health jurisdictions; and
   c) The identification of any barriers that may inhibit either the Department's or local health jurisdictions' ability to be more efficient and effective.
3) Review the extent to which public health services are being provided in a consistent manner throughout the state.
4) Determine the extent to which state laws and regulations related to public health clearly delineate the division of authority and responsibility between state and local entities. Additionally, assess the extent to which the division of authority and responsibility is generally understood, and deemed appropriate, by state and local public health officials.
5) Review the Department's biennial Public Health Improvement Plans, focusing in particular on the extent to which the plans comply with statutory directives, and the extent to which the plans' performance standards and measures provide substantive information for policy and decision-making purposes.
6) Review the processes used by the Department of Health and other state agencies to allocate state and federal public health-related funds to local jurisdictions, and assess whether funds are being allocated in a manner that is consistent with legislative intent, ensures accountability, and promotes equity and overall system effectiveness.

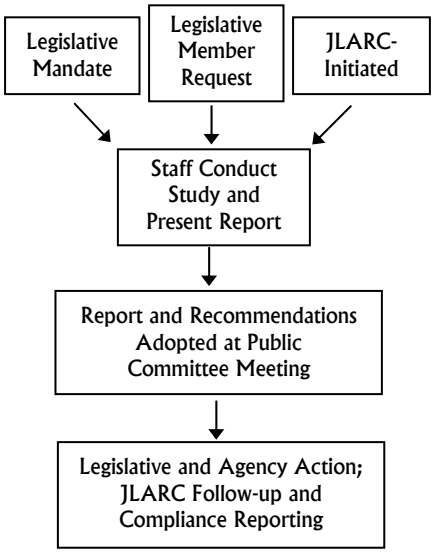
Timeframe for the Study

A Preliminary Report is scheduled for January 2007 and a Final Report for February 2007.

JLARC Staff Contact for the Study

Robert Krell (360) 786-5182 krell.robert@leg.wa.gov

JLARC Study Process



Criteria for Establishing JLARC Work Program Priorities

- Is study consistent with JLARC mission? Is it mandated?
- Is this an area of significant fiscal or program impact, a major policy issue facing the state, or otherwise of compelling public interest?
- Will there likely be substantive findings and recommendations?
- Is this the best use of JLARC resources: For example:
  - Is the JLARC the most appropriate agency to perform the work?
  - Would the study be nonduplicating?
  - Would this study be cost-effective compared to other projects (e.g., larger, more substantive studies take longer and cost more, but might also yield more useful results)?
- Is funding available to carry out the project?

APPENDIX 2 – AGENCY RESPONSES

- Department of Health
- Office of Financial Management

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47890 • Olympia, Washington 98504-7890
Tel: (360) 236-4501 • FAX: (360) 586-7424 • TDD Relay Service: 1-800-833-6388

April 5, 2007

Ruta Fanning
Joint Legislative Audit and
Review Committee
Post Office Box 40910
Olympia, Washington 98504-0910

Dear Ms. Fanning:

Thank you for the opportunity to comment on the preliminary report. My comments are as follows.

RECOMMENDATION	AGENCY POSITION	COMMENTS
Rec. 1	Concur	

Response to Recommendation

The department concurs that a review of the statutory language used to describe performance reporting in public health is needed. Changes to the statute could set the course for the future public health system that is accountable, effective and efficient.

The existing language was initially adopted in 1993, and then added to in 1995. In the decade-plus that has elapsed, there have been some changes in how the public health system communicates, plans for the future, and estimates needs. Simultaneously, there have been many developments in the field of performance management. Updated terminology, definitions, and clear expectations for both state and local government would be helpful.

The current language mixes many different objectives, including measuring overall public health system capacity, evaluating efficiency of individual jurisdictions, contrasting health outcomes from one locale to another, and estimating costs to provide resources needed to improve health outcomes. These are each complex challenges and they require different types of measurement.

As questions from the JLARC members at the March 21, 2007, meeting indicate, there are several factors that must be considered in conducting the review:

1. The current standards and measures have both value and limitations. They need to continue to evolve.

   Public health leaders in Washington undertook the effort to develop standards for public health in response to the requirement of RCW 43.70.520, adopted in 1993.

   At the time, there were no common standards for public health, in our state or nationally. The idea that local public health jurisdictions represented "a system" was new for many administrators. Historically, each county government organized its public health services independently of other counties and without direct oversight by the state. Funding levels, staffing, specific programs, and services all varied widely. Nothing was "the same" from one county to the next, so there was no solid basis upon which to compare, measure, or evaluate public health agencies.

2. Caution must be used in making spending-based comparisons among local jurisdictions. The underlying information is not the same.

   In the presentation to the committee on March 21, 2007, comparisons were made using per capita expenditures, overlaid with performance results. This provides an inaccurate picture because the underlying information is very different for each local jurisdiction.

   To fully understand the impact of this variation on health, much more detailed information would be needed. Information systems would need to be established to track expenditures and service delivery data so that comparable information was available for analysis.

3. Linking key health outcomes and performance evaluation must be done carefully.

   Any comparisons among counties based on differences in health status must be made very carefully. First, the variation in population size limits the ability to compare statistics so that they are meaningful. Second, the underlying reasons for health problems, linked to determinants of health, vary according to the characteristics of a population. For example, factors such as income, education, nutrition, and behavior are of great importance.

4. It is important to clarify state and local responsibilities. The present system is a local/state government partnership without clear central authority.

   Washington's public health resources are firmly rooted in a local government. While the Department of Health is an indispensable partner in making the system work, the department does not have direct oversight of the budgets, programs, or staff resources established locally.

Today, the public health system is pursuing improvement through a partnership of state and local government. Participation has been voluntary. There has been no attempt to reduce the level of authority exercised locally and allowed by law.

5. Department of Health contracts with local health reflect categorical restrictions on the use of funds.

   The Department of Health has contracts with local health jurisdictions for many individual programs and services that are categorical—state or federal funds which can only be spent on a specific service. The requirements for categorically-based contracts are proscribed by the funding agency and there is limited opportunity to develop alternative performance-based measures beyond those requirements.

I appreciate the opportunity to respond to the preliminary JLARC report, and look forward to the hearing on the final report.

Sincerely,

Mary C. Selecky
Secretary

cc: Victor Moore, Office of Financial Management
Nick Lutes, Office of Financial Management
Christina Hulet, Office of the Governor

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J LARC

April 3, 2007

TO: Ruta Fanning, Legislative Auditor
Joint Legislative Audit and Review Committee

FROM: Victor A. Moore, Director

SUBJECT: **REVIEW OF WASHINGTON'S PUBLIC HEALTH SYSTEM -- PRELIMINARY REPORT**

Thank you for giving the Office of Financial Management (OFM) the opportunity to review JLARC's preliminary report on the review of Washington's Public Health System.

OFM concurs with the recommendation in this preliminary report.

Recommendation	Agency Position	Comments
1. The Department of Health should review the statutory language used to describe the performance reporting requirements for the public health system and make suggestions to update the language in light of current practices, while maintaining requirements to provide important performance information. As part of its review, the Department should identify appropriate language to link contracted funds with performance. The Department should deliver its suggested changes to the language in the public health performance reporting statutes in a report to the Legislature by December 2007.	Concur	

We look forward to your final report. If you have any questions, please contact Nick Lutes at (360) 902-0570.

APPENDIX 3 – REVISED STANDARDS FOR PUBLIC HEALTH

Note: This version of the minimum standards for public health will be used in an assessment of state and local public health agencies in 2008. Under each of the standards there are measures that are specific either to local health jurisdictions or to the State Board of Health and Department of Health.

Revised Standards for Public 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.

Revised Standards for Public Health
Standard 8: Program Planning and Evaluation
• Public health programs and activities identify specific goals, objectives, and performance measures and establish mechanisms for regular tracking, reporting, and use of results.
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.

Source: 2006 Public Health Improvement Plan, pages 54 – 55.

APPENDIX 4 – REPORT CARD ON HEALTH IN WASHINGTON 2005

See following pages.

What is a Report Card on Health?

Since 1999, the Public Health Improvement Partnership's Key Health Indicators Committee has reviewed a multitude of possible measures, studied the work of several states, and sifted through the data thoughtfully and carefully. The goal is to answer the question "How healthy are we?" Therefore, the report card was developed to take a deeper look at health, focusing on the "determinants of health" and measuring those that have the greatest impact on our health. The contribution of medical care is important, and it is essential when a person becomes ill. But other factors have a much greater impact on our overall health, including personal behaviors, such as smoking and physical activity and the social and physical environment in which we live.

Who is being graded?
All of Washington state.

What is being graded?
Overall health and factors in our environment, communities, families, and ourselves that affect health.

How are we grading?
We are looking at more than 50 measures. The grades reflect how we compare to the United States, if we are getting better or worse over time, and how well we are doing to eliminate health disparities among our different racial/ethnic populations.

Why are we putting out a report card?
This report card is intended to inform and stimulate state and community discussion, as well as policy development and action, by providing solid information that will lead to more focused actions, and ultimately, better health.

The report card will be updated with new data every two years to identify areas that need addressing for improving health in Washington. The report card website will provide information on each of the measures and grading components.

The report card, along with a complete description of the grading criteria, the rationale for assigning each grade, the indicator definitions and data sources, and the data tables can be found at: www.doh.wa.gov/reportcard.

The indicators fall into the following categories:

1. How healthy are we overall?
2. How safe and supportive are our surroundings?
3. How safe and supportive are our communities?
4. How supportive is our health care system?
5. How safe and supportive are our families?
6. How healthy are our behaviors?

PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND HEALTHIER WASHINGTON

1. How Healthy Are We Overall?

Category	Indicators	Compared to U.S.	Trend	Disparities	Final
How good is our general physical and mental health?	Expected years of healthy life at age 20	A	F	B	C
	Percent of adults who report 14 or more days of poor mental health in the past month	B	D	C	C
Overall Grade	Although Washington compares favorably to the U.S. on healthy life expectancy and mental health, there are moderate levels of disparities and indications that larger proportions of Washington residents are experiencing poor physical and mental health.				C
Are we a healthy weight?	Percent of adults who are obese	B	F	C	C
	Percent of 10th graders who are overweight	B	NA*	B	B
Overall Grade	Washington has relatively fewer obese adults and overweight 10th graders compared to the U.S. Nonetheless, in 2004 about one in five adults reported heights and weights indicating obesity. About 10% of 10th graders were overweight in 2004. Washington's rates are moving in the wrong direction and we have moderate levels of disparities.				C

2. How Safe and Supportive Are Our Surroundings?

Category	Indicators	Compared to U.S.	Trend	Disparities	Final
Do we have illnesses commonly associated with unsafe food, unsafe water, and poor hygiene?	Rate of campylobacteriosis per 100,000 population	NA	A	NA	A
	Rate of E. coli O157:H7 infection per 100,000 population	F	A	NA	C
	Rate of giardiasis per 100,000 population	NA	A	NA	A
	Rate of listeriosis per 100,000 population	C	A	NA	B
	Rate of salmonellosis per 100,000 population	A	A	B	A

*NA = Currently not available

2. How Safe and Supportive Are Our Surroundings? (Continued)

Category	Indicators	Compared to U.S.	Trend	Disparities	Final
Do we have illnesses commonly associated with unsafe food, unsafe water, and poor hygiene?	Rate of shigellosis per 100,000 population	A	A	C	B
	Rate of vibriosis (non-cholera) per 100,000 population	NA	C	NA	C
	Rate of yersiniosis per 100,000 population	NA	A	NA	A
Overall Grade	Except for rates of E. coli O157:H7, Washington's rates of illness associated with unsafe food, unsafe water and poor hygiene are the same or lower than those in the U.S. For all illnesses except vibriosis, Washington's rates are decreasing or there have been three or fewer reports for the last three years. Because of the small number of reports or missing race and ethnicity data, most of these indicators do not have grades for disparities.				B
Do we have clean drinking water?	Of the population whose homes receive water from Group A public water systems, the percent on systems in compliance with nitrate monitoring requirements	NA	A	NA	A
	Of the population whose homes receive water from Group A public water systems, the percent on systems in compliance with quality standards for nitrates	A	A	NA	A
	Of the population whose homes receive water from Group A public water systems, the percent on systems in compliance with coliform monitoring requirements	NA	C	NA	C
	Of the population whose homes receive water from Group A public water systems, the percent on systems in compliance with quality standards for coliform bacteria	A	A	NA	A
	An indicator for Group B systems is under development	UNDER DEVELOPMENT			
Overall Grade	Based on available data, Washington residents on group A systems have safe drinking water.				B
Do we have clean air to breathe?	Percent of population breathing air that is meeting the National Ambient Air Quality Standards (NAAQS)	A	A	A	A
Overall Grade	Based on the NAAQS, Washingtonians enjoy good air quality. However, U.S. Environmental Protection Agency staff has recommended strengthening the NAAQS for very small particles to protect health. Washingtonians may breathe unhealthy air due to natural events, such as windblown dust, or due to air pollutants that are not regulated in the NAAQS, such as fine particles specifically from diesel exhaust and benzene.				A

*NA = Currently not available

3. How Safe and Supportive Are Our Communities?

Category	Indicators	Compared to U.S.	Trend	Disparities	Final
Do our incomes meet basic financial needs?	Percent of people living below the U.S. poverty level.	C	F	C	D
Overall Grade	The percent of people living below the U.S. poverty level seems to be increasing. There are moderate levels of disparities.				D
Are we connected to our communities?	Percent of adults reporting that most people can be trusted	A	NA	B	B
	Percent of high school students dropping out of school	NA	C	C	C
	Rate of serious violent crime offenses per 100,000 population	A	A	F	B
Overall Grade	Washington has relatively low crime and high social trust. However, there are large race/ethnic disparities in reported violent offenses.				B
Are we getting injured unnecessarily?	Unintentional motor vehicle deaths per100,000 population	A	A	D	B
	Unintentional poisoning deaths per 100,000 population	F	F	F	F
	Unintentional drowning deaths per 100,000 population	D	A	B	B
	Unintentional fall-related deaths among persons 65 years and older per 100,000 population	F	F	B	D
Overall Grade	Except for motor vehicle deaths, Washington death rates from unintentional injury are higher than the U.S. rates. While rates for motor vehicle and drowning deaths have been decreasing, rates have increased for poisoning and falls among person ages 65 and older. There are high levels of disparities for motor vehicle deaths and poisoning.				C

*NA = Currently not available

4. How Supportive Is Our Health Care System?

Category	Indicators	Compared to U.S.	Trend	Disparities	Final
Are we able to get medical care when we need it?	Percent of households with people unable to obtain health care or experiencing a delay in obtaining health care	NA	NA	B	B
Overall Grade	With only one grading component and one indicator, this subject cannot be graded.				NA
Do we have illnesses that could be prevented by immunization?	Rate of hepatitis A per 100,000 population	A	A	B	A
	Rate of hepatitis B per 100,000 population	B	B	NA	B
	Rate of measles per 100,000 population	C	C	NA	C
	Rate of mumps per 100,000 population	B	A	NA	B
	Rate of pertussis per 100,000 population	D	F	NA	F
	Rate of polio per 100,000 population	A	A	A	A
	Rate of rubella per 100,000 population	A	C	A	B
	Rate of tetanus per 100,000 population	A	A	A	A
Overall Grade	Grades for vaccine preventable disease vary depending on the disease. Washington sees no or few cases of polio and tetanus, but there is room for improvement in controlling other diseases, especially pertussis. Periodic outbreaks can cause rates of measles and rubella to vary from year to year. Measles and mumps outbreaks are often associated with exposures in countries with high rates of these diseases.				B

*NA = Currently not available

5. How Safe and Supportive Are Our Families?

Category	Indicators	Compared to U.S.	Trend	Disparities	Final
Are we planning for and spending time with our families?	Percent of pregnancies that are intended	NA	C	B	C
	Percent of families that regularly read to their young children	NA	NA	NA	NA
	Percent of 10th graders who report most of the time or always eating dinner with their family	NA	NA	B	B
Overall Grade	Given that there are only two indicators with grades, one of which has a grade for only one component, there are not sufficient data to assign an overall grade.				NA
Are our families safe?	Number of offenses involving domestic violence per 1,000 population	NA	C	NA	C
	Number of children reported as abused or neglected per 1,000 children	NA	C	F	D
Overall Grade	Given that there are only two indicators one of which has a grade for only one component, there are not sufficient data to assign an overall grade.				NA

6. How Healthy Are Our Behaviors?

Category	Indicators	Compared to U.S.	Trend	Disparities	Final
Do we smoke cigarettes?	Percent of adults reporting current cigarette smoking	B	A	C	B
	Percent of 10th graders who report smoking cigarettes in the past 30 days	A	A	C	B
	Percent of women who report smoking during the last 3 months of pregnancy	NA	B	F	D
Overall Grade	With about 20% of adults and 13% of 10th graders reporting smoking, Washingtonians smoke less than persons in the U.S. as a whole, and smoking in Washington has been declining. Smoking varies significantly by race and ethnic group. Smoking among Hispanic women during pregnancy is especially low, setting a high standard that other groups could achieve.				B

*NA = Currently not available

6. How Healthy Are Our Behaviors? (Continued)

Category	Indicators	Compared to U.S.	Trend	Disparities	Final
Are we physically active?	Percent of adults who report meeting recommendations for moderate or vigorous physical activity through work or leisure	A	NA	B	B
	Percent of 10th graders who report meeting recommendations for vigorous physical activity	A	NA	B	B
Overall Grade	Washingtonians are more physically active than persons in the U.S. as a whole. However, like the U.S., there is much room for improvement; approximately 1/4 of 10th graders and 1/3 of adults are not physically active at levels recommended for maintaining good health.				B
Are we eating right?	Percent of adults who report eating fruits and vegetables 5 or more times daily	C	C	B	C
	Percent of 10th graders who report eating fruits and vegetables 5 or more times daily in the past week	C	NA	B	C
	Percent of 10th graders who report drinking 2 or more non-diet sodas yesterday	NA	NA	C	C
Overall Grade	The percent of Washingtonians eating fruits and vegetables at least 5 times each day is similar to the percent for the U.S. Based on the 23% eating fruits and vegetables 5 times each day in 2003, we estimate that about half of adults meet the recommended 5 servings daily. Despite much room for improvement, percents in Washington are not increasing.				C
Do we abuse alcohol?	Percent of adults who report having 5 or more alcoholic drinks on one occasion during the past 30 days	C	C	B	C
	Percent of adults reporting chronic heavy drinking in the past 30 days: women who report more than 1 drink per day and men who report more than 2 drinks per day	C	C	C	C
	Percent of 10th graders who report drinking any alcohol in the past 30 days	B	NA	B	B
Overall Grade	Levels of unhealthy drinking are similar among adults in Washington and the US. Although about a third of 10th graders reported drinking alcohol in the past 30 days in 2004, drinking among 10th graders has been somewhat lower in Washington than in the U.S. Rates of unhealthy drinking have generally been constant for adults in Washington.				C

*NA = Currently not available