The Implementation of Model Standards in Local Health Departments

PHILIP WEILER, MD, JANE BOGGESS, PHD, EILEEN EASTMAN, MA, AND BRUCE POMER, MPA

Abstract: Four local health departments in California tested a process of state/local negotiations for the purpose of implementing model standards in community preventive health services. The standards, which covered five program areas, had been developed by a collaborative work group of representatives from the United States Conference of City Health Officers, the National Association of County Health Officials, the Association of State and Territorial Health Officials, the American Public Health Association, and the US Department of Health, Education, and Welfare. Evaluation of the project indicates that the success of the negotiation transactions and results varied, both among local health departments and program areas. A number of factors have been identified as influencing the negotiations, including the availability of baseline data, the extent to which individual programs are currently affected by required standards of performance, and health department attitude toward the project.

The future utility of this model is considered within the broader context of changes now occurring in the financing and organization of public health within the United States. Project findings suggest that the Model Standards negotiations could provide state and local levels of government with a valuable management tool for determining health care priorities and generating objective programmatic data for budget justification. (Am J Public Health 1982; 72:1230–1237.)

Introduction

Recent federal health budgetary proposals are expected to have a significant impact on the structure and financing of the public health system within the United States. A major development has been a substantial reduction in federal expenditures for health services, with the partial consolidation of many categorical grants into state administered block grants. As a result of these developments, it is anticipated that changes will occur in local public health department programs and priorities, and that both state and local policy makers will be given considerably more discretion in shaping the health care system of the 1980s than they have had in the recent past.

Block grants, the primary vehicle for the federal return of control to states, are intended to allow states to tailor spending to meet their own local needs. Critical to the block grant concept is the reduction of federal regulations and reporting requirements, with the power of accountability becoming a state and local prerogative. Although Congressional actions have diminished much of the original flexibility inherent in the block grant concept, the Reagan Administration remains firm in its commitment to return health responsibility to the local level. Within the next few years, the number of federal health programs that are shifted into block grants is likely to grow, while the number of federal regulations governing local requirements of performance will most likely shrink.

These proposed changes have generated a major controversy. In addition to the issues surrounding federal budget reductions, concern has been expressed about how prepared the states are to deal with this expansion of responsibility. The question of program accountability and the mechanism whereby providers funded under block grants will be monitored and assessed is one of several key problems that states will be confronted with in the near future.

This paper presents the results of a study in California in which a process of mutual state/local negotiation, involving model standards for community public health programs, was tested. The framework for the negotiations was designed to allow standards and program priorities to be tailored to local conditions through input from state and county health officials. It is suggested that the model presented here has special relevance for the current public health issues noted, specifically for the area of state/local accountability under the block grant mechanism.

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Background

Public Law 95-83, the 1977 Health Planning and Health Services Research and Statistical Extension Act, provided for the development of model standards for community preventive health services. A collaborative work group was established with representation from the American Public Health Association, the Association of State and Territorial Health Officials, the National Association of County Health Officials, and the United States Conference of City Health Officers. Standards were established for a group of 28 programs, and a conceptual framework developed for the implementation of these standards. Model Standards for Community Preventive Health Services, the work group’s Report to Congress, was published by the Centers for Disease Control in 1979. Subsequently, the California State Department of Health Services and the Maine Department of Human Services were awarded contracts to implement and evaluate these model standards.

In California, the administrative relationship between local health departments and the state government is largely decentralized, with local health officers having a high degree of administrative autonomy. There are 58 counties and 60 local health officers. Of these, four are city health officers and the rest are county—with two bi-county health departments. County health officers are appointed by their respective county Board of Supervisors, the local governing agencies.

Local health officers have a strong working relationship with the California State Department of Health Services. They are represented by a statutory organization, the California Conference of Local Health Officers (CCLHO), and through this organization have the right to review and comment on all regulations and a number of policy proposals of the California Department of Health Services and to review and approve those which deal with the actual operations of local health departments.

Project Design and Methods

The Model Standards project in California had three objectives: 1) to test a negotiation process enabling state and local negotiators to come to an agreement on the implementation of specific model standards; 2) to develop the appropriate methodology for evaluating the negotiation process and standards implementation; and 3) to survey and analyze the expectations and objectives of project participants.

The standards concept used in the project embodies, for each program area, a goal statement, together with a number of related “outcome” and “process” objectives.** Flexibility in tailoring standards to local conditions was preserved through a “fill in the blank” formula. For each objective, negotiators were given the opportunity to set a county-specific change in outcome measure or the delivery of services to be attained within one year’s time. By taking local factors into consideration, the amount of change could then reflect program area priorities and accommodate local resources. The agreements reached by state and local negotiators about the increase (or decrease) in services or measures of outcome were “formal” in nature but legally nonbinding.

Central to the project design was the selection of an appropriate subcontractor. Because the California Department of Health Services was an active participant in the project, and represented the State in the state-local negotiations, an independent organization was needed to observe and evaluate the project. The Health Officers Association of California (HOAC)—a private nonprofit corporation conducting public health legislative, research, and educational activities in California—was chosen as subcontractor. In addition to its evaluation function, HOAC brought an important benefit to the project. Because of the role of its membership in developing public health policy in California, HOAC was able to ensure a climate of strong cooperation with local health department participants.

Five program areas were selected out of the group of 28 for which Model Standards have been developed: Communicable Disease Control***; Health Education; Public Health Laboratory; Maternal and Child Health; and Safe Drinking Water. These programs were selected because they represent traditional Public Health programs and vary in such key aspects as: 1) the complexity of their implementation; 2) the amount of ongoing consultation provided by the State to local health departments; 3) the degree that they currently are covered by standards in the form of laws, regulations and non-mandated guidelines; and 4) the extent of their currently available public health services. Four counties participated in the project; criteria for their inclusion in the project were that they represent as wide a cross section as possible, so that the process could be tested under various conditions. Characteristics of the counties are shown in Table 1.

Assessment Questionnaire

Preliminary to the negotiations, state and local participants were given assessment questionnaires which presented the outcome and process objectives developed for each program area. The questionnaires were completed on a county-by-county basis: local participants in each county filled it out for their own county, and, at the state level, participants completed separate questionnaires for each of the four counties. The program assessment questionnaires requested three basic types of information from state and local participants. For each objective they were first asked to assess its current status within the county. For outcome objectives this entailed quantifying specific health problems; for process objectives it involved measuring current program

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**The specification of quantifiable outcome objectives in the Model Standards endeavor represents an important departure from most other standards setting efforts which have tended to be service delivery oriented. For a more detailed description of the Model Standards construct and scope see: Model Standards for Community Preventive Health Services, and Appendix Table 1.

***Communicable Disease Control included three programs (Immunization, Sexually Transmitted Diseases, and Tuberculosis), which were negotiated independently.
WEILER, ET AL.

TABLE 1—Characteristics of Participating California Local Health Departments

<table>
<thead>
<tr>
<th>County</th>
<th>Type of Local Health Department Jurisdiction</th>
<th>No. of Health Department Employees (FTE)¹</th>
<th>Public Health Services Expenditures 1980–1981²</th>
<th>Total County Population³</th>
<th>Per Cent Minority⁴</th>
<th>Per Cent of Population Urban⁴</th>
<th>Per Cent of Population Below Poverty Level⁴</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merced</td>
<td>county</td>
<td>85</td>
<td>2,971,895</td>
<td>134,560</td>
<td>33.9</td>
<td>62.3</td>
<td>16.9</td>
</tr>
<tr>
<td>San Bernardino</td>
<td>county</td>
<td>513</td>
<td>13,167,900</td>
<td>893,157</td>
<td>27.0</td>
<td>90.1</td>
<td>12.2</td>
</tr>
<tr>
<td>San Francisco</td>
<td>city-county</td>
<td>1,127</td>
<td>15,699,206</td>
<td>678,974</td>
<td>47.7</td>
<td>100.0</td>
<td>14.0</td>
</tr>
<tr>
<td>Siskiyou</td>
<td>county</td>
<td>19</td>
<td>699,827</td>
<td>39,732</td>
<td>10.5</td>
<td>29.3</td>
<td>12.2</td>
</tr>
</tbody>
</table>

¹ Number of staff exclusive of employees in public hospitals under the jurisdiction of local health departments.
² Data derived from the County Health Services Report, Office of County Health Services and Local Public Health Assistance, California State Department of Health Services, January 1982. Figures for public health expenditures represent estimated budgets for as many as 14 categories of public services: Chronic Disease Control, Maternal and Child Health, California (Crippled) Children’s Services, Dental Services, Environmental Health, Public Health Laboratory Services, Communicable Disease Control and Epidemiological Services, Community Health Statistics, Health Services for the Elderly, Emergency and Disaster Services, Public Health Nursing Field Services, Health Promotion and Health Education, Other Public Health Programs, and Administrative and Other Support Services. California Law requires county governments to provide medical care to the poor. The law, however, does not specify the services to be provided or precisely define the population eligible. As a consequence, public health services provided by local health departments, and their per capita expenditures, vary from county to county.
³ Data derived from the 1980 census, and reported in Health Data Summaries for California Counties, 1982, Center for Health Statistics, California State Department of Health Services. Minority sector defined as Black, other non-White, and Hispanic.
⁴ Data obtained from 1970 census and reported in Health Data Summaries for California Counties, 1980.

efforts which contribute to the reduction and prevention of particular health problems. Next, participants were asked to set an incremental increase in the delivery of services or the measure of outcome to be achieved within one year’s time. Finally, they were requested to determine the indicators that could be used to show achievement of the objective.

The results of the assessment questionnaire were compared: if local and state participants disagreed, the objective was put on a negotiation agenda and discussed at the actual negotiation sessions. If they agreed, it was put on a consent calendar. Thus, the consent calendar formed the first series of agreements resulting from the negotiation process. Both the consent calendar and the negotiation agenda were distributed to state and local participants for their review and comment, and modifications of these documents were made when requested.

Negotiation Protocols

The negotiation protocols we developed set forth the terms of participation. The state negotiators selected had broad programmatic knowledge and authority. Each program at the state level was represented by a single negotiator, with the exception of Maternal and Child Health which had two. Selection of local negotiators was the prerogative of the local health department. The smaller health departments were represented by the health officer and one or more staff members and larger departments by program unit chiefs and high level administrative staff.

The negotiation format was relatively informal, although structured to ensure that equal time was given to both state and county participants. Actual discussion of each objective started with a statement given by the state participant and the county participant. The statement summarized the participant’s position on the item in question and the underlying reasons for the position. After each of the two parties was given the opportunity to consider the other supporting arguments, the negotiators entered into an informal exchange in which information and/or terms and definitions were re-examined and an agreement was reached.

Evaluation

The evaluation addressed both the negotiation transactions and results. For negotiation transaction, emphasis was placed on the nature of exchange between participants, and the evaluation was designed to answer the following types of questions:

- Is the exchange interactive, with input from both local and state participants?
- Are the negotiation protocols well received by participants?
- Do county officials appear to feel a sense of “ownership” of the agreements reached?

In qualitative terms, it was hoped that the negotiations would result in highly interactive and informative sessions, with state and local participants expressing a strong sense of involvement in, and commitment to, the project. Data for measuring the negotiation transactions were obtained through a survey of participant attitudes distributed at the end of each negotiation session, and an analytic description of individual sessions provided by an independent observer.

Two primary goals were set for the negotiation results: 1) to have state and local participants reach agreement on program objectives; and 2) to have state and local participants determine current activity levels; make commitments to incrementally increase services or outcome measures; and establish indicators for program objectives.

†Agreement was defined as simply the state and county coming to a common consent. Thus, in the assessment questionnaire, if both the state and county independently agreed that an objective could not be addressed (e.g., because there were no available baseline data) this was scored as an agreement. Similarly, if during the negotiation sessions both state and local participants agreed that no improvement could be made in the forthcoming year, this also was scored as agreement. In evaluating results, the negotiations were broadly defined to include the agreements reached through both the assessment questionnaire and the actual face-to-face negotiation sessions.
Results

The negotiations were held during the summer of 1981. For each county, the sessions lasted approximately two days and the program areas were negotiated consecutively. For the most part, the structure of the negotiation protocols was honored. However, further specification of some objectives occurred, an aspect of the negotiations that was not initially included in the project design. Additionally, one program was rescheduled and repeated when, at the first session, it was apparent that the state negotiator lacked the sufficient knowledge and authority to deal with this particularly broad program.

On the basis of survey response, the negotiation format was well received. Both sides were generally satisfied with responsibilities assumed at the state and local level. The concept of mutual negotiations, involving standards that could be adjusted to local needs and resources, appeared to be attractive to many participants.

However, in spite of the generally favorable survey response, it was evident to the project monitor, the person responsible for independently observing the sessions, that the transactions of the negotiations were not uniformly successful among all counties and programs. The extent of discussion of objectives varied widely among programs, tending to be most limited, and probably least productive, for Communicable Disease Control programs, and comparatively more effective for Safe Drinking Water and Health Education. The degree to which participants were actually receptive to the project also appeared to vary, particularly among counties. As discussed in the following section, there are a number of factors which were judged to affect this variability in success of the negotiation transactions.

In terms of negotiation results, and reaching agreements about the objectives, the assessment questionnaire was a fairly effective tool, with approximately half (57 per cent) of the total number of objectives agreed upon through this initial procedure. Reasons for not reaching initial agreement were grouped into three major categories: 1) the state and counties disagree about one or more components of the objective; 2) the state or county specifically requests that the objective be brought to the negotiation table; and 3) either the state or the county fails to supply appropriate information requested on the assessment questionnaire (e.g., does not specify indicators, and so forth). In about one-half (48 per cent) of the cases brought to the negotiation table, the county and state actually disagreed or specifically requested that the objective be discussed. In the remaining cases, one side failed to supply requested information.††

††All agreements for Public Health Laboratory, which consists of only one objective, were reached through the assessment questionnaire. Because the sample of data from this program is so small, it has generally been omitted from the Results or Discussion sections of this paper.

†††Reasons for failing to supply the requested information varied. Most commonly, however, it was because of lack of data, or because the participant felt the objective needed further specification.

As a mechanism for achieving state/local agreement about objectives, the actual negotiation sessions were extremely successful. Through the information that was exchanged during these sessions, common consent was achieved by state and local participants for virtually all objectives. However, for the second goal (establishing current activity levels; setting projected activity levels; determining indicators), the negotiations were somewhat less successful, with participants being unable to determine the required data or make commitments for a significant number of objectives. As would be expected, it was easier for participants to establish baseline data for current activity levels and determine indicators for showing achievement than it was to make specific commitments to increase delivery of services or measures of outcome (Table 2).

If these data are compared by program and by county, it is clear that the results of the negotiations varied greatly among programs and to a lesser extent among counties. Health Education was the most successful program in terms of negotiation results, with almost all (90 per cent) of its objectives being implemented (i.e., current activity level and indicators established and commitment made to increase delivery of services). Less successful were the Maternal and Child Health and Communicable Disease Control programs, with about 19 per cent and 28 per cent of their respective objectives being successfully implemented.* Variability among individual counties was less pronounced with a percent spread of only 18 points for successfully implementing objectives among individual health departments.

TABLE 2—Outcome of Negotiations

<table>
<thead>
<tr>
<th>Objective</th>
<th>Current Activity Level Established</th>
<th>Incremental Increase Achieved</th>
<th>Indicators Established</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Objectives (N = 408)</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Objectives Not Already Achieved (N = 228)*</td>
<td>80</td>
<td>24</td>
<td>62</td>
</tr>
</tbody>
</table>

*It is noteworthy that little difference exists among individual counties in the number of objectives that they had already achieved. The greatest number of objectives that any one county had already achieved was 47, and the smallest 40. In contrast, there is a significant difference among the programs in the numbers of objectives counties had already achieved, with a large number (74%) of the Safe Drinking Water objectives having already been achieved, but only 20% of the Maternal and Child Health Objectives currently achieved.

*The programs vary widely in their numbers of process and outcome objectives (see Appendix Table 2). Health Education, for example, has only five process objectives, whereas Maternal and Child Health has 35 process and outcome objectives. If one examines the absolute number of objectives for which a commitment was made to increase services or measures of outcome, Maternal and Child Health fared best with 26 of its objectives being successfully negotiated in all four counties. The broad negotiation process for Immunization resulted in the fewest number (only eight) of objectives for which commitments were made to increase services or the measures of outcome.
As a part of the negotiation results, the final agreements were evaluated with respect to the initial state/county positions on the objectives.** These data have one particularly notable feature: for more than half (62 per cent) of the successfully negotiated objectives, the counties did not commit themselves to a greater increase in delivery of services or measures of outcome than they had independently proposed in the assessment questionnaire. This is open to interpretation. Most favorably, it can be viewed that the broad negotiation process served as a self-assessment tool for the counties and that commitments to increase services or measures of outcome were not so much extracted from them by state negotiators as arrived at on their own. In other words, after counties agreed to participate in the project, they generally “bought into” the Model Standards process. Less favorably, it could be argued that because the agreements were legally nonbinding, the state negotiators had relatively little leverage with which to bargain.

Discussion

A number of variables have been identified which appear to have influenced the negotiation transactions and results. The county’s attitude toward the project’s uses and consequences obviously impacted transactions of the negotiations. In evaluating this aspect on a county-by-county basis, it is evident that it was most successful in the county where local health officials were known to be independently receptive to the process and viewed the concept of mutual negotiations of model standards as an idea “whose time has come.” In contrast, the transactions were comparatively less successful in one of the other health department where officials appeared to be apprehensive about the kinds of decisions that might result from conclusions of the project, and possibly resentful over the potential loss of control of their activities. It is significant, however, that in this particular county where the negotiation transactions were comparatively less successful, the negotiation results were the most successful with the health department there setting more incremental increases for objectives than any other department.

Frequency of program specific contact between the state and local negotiators most likely also affected the negotiation transactions. For example, the state negotiator representing Safe Drinking Water had ongoing contact with local participants in three of the four test counties. He was viewed by county participants as having accurate expectations of what needed to be—and what could be—done at the local level. This strong liaison between state and county was probably an important factor in making the negotiation transactions for Safe Drinking Water among the most successful of all programs.

The extent to which the various programs are covered by required standards of performance had a major influence on negotiation transactions and results. Immunization and Sexually Transmitted Diseases, two of the Communicable Disease Control programs, currently have federal requirements of performance that are both comprehensive and demanding. As a result, dialogue during these sessions was limited and there were relatively few new commitments made to incrementally increase objectives. In contrast, the Health Education program is largely governed by nonmandated guidelines. This program was extremely successful, with all four counties setting an increase in services for virtually all Health Education objectives.

Availability of data was another important factor affecting negotiation results. The programs varied considerably in availability of baseline data required for addressing objectives. Maternal and Child Health had the largest number of objectives for which no baseline data were available at either the state or local level. As a result, the results of this program were comparatively poor. Two other problems sometimes affected successful negotiation of objectives: some of the objectives fell outside the purview of local health departments; and a few of the objectives, particularly in Sexually Transmitted Diseases, did not reflect the current state of the art in preventive medical technology.

As stated before, further specification of objectives occurred during the actual negotiation sessions when both parties agreed that the objective, as written, was not applicable. Thus, some of the problems were circumvented by adjusting the scope of objectives in question. Because this process was not built into the design of the project, it tended to occur on a somewhat ad hoc basis. A more favorable situation would be to convene statewide program participants for the purpose of reviewing Model Standards’ objectives before distributing the assessment questionnaires.***

This could entail, when necessary, redefinition and possible deletion of some objectives and inclusion of new objectives.

It is suggested that this would enhance the Model Standards negotiations in two important ways. Convening such program-specific statewide meetings would promote commitment to the project and give participants a greater sense of “ownership” of standards. Additionally, the discussion, and the information exchanged during these meetings would function to further develop the “self-assessment” aspect of the Model Standards process, and enhance its use to counties as a management tool. These meetings, involving both state and local representatives, would also offer an opportunity for setting statewide priorities in which, for example, a core of program objectives could be adopted as central to the forthcoming negotiations. Local priority setting, where local health jurisdictions identify those programs and components of programs to be given emphasis during forthcoming funding cycles, would then follow these state-

**Since it was impossible to reliably determine the actual bargaining position of the state and county at the negotiation sessions, the written positions expressed by the state and county on the assessment questionnaire were used as the baseline for determining “wins” and “losses”.

***Through the CCLHO committee process, California is now in the process of reviewing the objectives presented in the Model Standards for Community Preventive Health Services* for their possible future role in administering block grants.
wide meetings. By reviewing the standards, and any existing statewide objectives, local health department staff would have a basis for determining budget allocations, particularly as they relate to future negotiated commitments about local incremental improvement objective.

Ultimately, availability of resources governed many of the decisions made about setting new increases in program objectives, and undeniably was the single most important variable affecting the negotiation results, especially among counties. The health departments tested in California ranged considerably in size, with the smallest having approximately 15 employees and the largest several thousand. In tailoring the negotiations to individual counties, local resources are a prime consideration, with the results from this study indicating that the expected number of incremental increases in objectives for any given period be proportionally adjusted to variation in health department resources.

The potential benefits of the Model Standards process just described are both timely and relevant to the changes now occurring within the United States public health system. The model presented here comes during a period of increasing dissatisfaction with federally imposed solutions for the health field, and offers an opportunity to establish a new process of interaction between local, state, and federal levels of government. The Model Standards process is a method of enhancing communication between the state and locals for the purpose of establishing state/local health policy and priorities. With the federal government divesting itself of much of its policy making role, and transferring this function to states, the need for a mechanism to facilitate this transition is obvious.

The implementation of block grants is a focal point of the anticipated expansion in state and local responsibility, and will be a primary area for testing state and local management expertise. As a management tool, the Model Standards process, or one similar to it, would provide states and locals with a suitable framework for shaping local health care policy, and a means of generating objective programmatic data for budget justification. Its process of mutual negotiations leads to program objectives developed jointly and acceptable to both state and local levels of government. Equally important, its format allows for locale-specific flexibility in setting levels of service and measures of outcome. Local health departments can identify program objectives that are both measurable and attainable, and relevant to the delivery of public health services within their own jurisdiction. As stated by Tilson, the Model Standards approach offers the opportunity for counties to be different from one another while ensuring that public health does not lose sight of its broader uniformity and unity of purpose.

REFERENCES

ACKNOWLEDGMENTS
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1In the Model Standards project, a small amount of money was available to each of the four counties for the cost of preparing the assessment questionnaire, attending the negotiation sessions, and providing the data required at the end of the project for final evaluation, but not for the work load involved in implementing new standards.
**APPENDIX TABLE 1—Sample of Objectives Negotiated during the California Model Standards Project: Tuberculosis**

<table>
<thead>
<tr>
<th>Goal Statement: Tuberculosis will be eradicated from the community.</th>
<th>Components of Objectives Assessed and Negotiated during the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome 1:</strong> By 19____ the new tuberculosis case rate will not exceed</td>
<td>1. For both indigenous and imported tuberculosis, what are the current new tuberculosis case rates?</td>
</tr>
<tr>
<td>___________</td>
<td>2. For both indigenous and imported tuberculosis, by what per cent can you reduce the case rate(s) by 6-30-82? _______</td>
</tr>
<tr>
<td></td>
<td>3. How can achievement of this objective be measured or demonstrated? ________________________</td>
</tr>
<tr>
<td><strong>Outcome 2:</strong> By 19____ at least 95 per cent of new positive sputum tuberculosis cases reported will convert their sputum to negative within 6 months.</td>
<td>1. What per cent of cases currently are converted to negative within six months? __________</td>
</tr>
<tr>
<td>___________</td>
<td>2. By what per cent will you increase the number of cases converting to negative within six months by 6-30-82? _______</td>
</tr>
<tr>
<td></td>
<td>3. How can achievement of this objective be measured or demonstrated? ________________________</td>
</tr>
<tr>
<td><strong>Process 1:</strong> By 19____ each community will be served by an agency responsible for overall tuberculosis prevention and control activities, including:</td>
<td>1. Do you currently have such an agency? ______ Yes ______ No</td>
</tr>
<tr>
<td>a) Maintenance of surveillance system and case registry to ensure reporting of positive bacteriology from laboratories and prompt reporting of cases from private physicians and medical care facilities;</td>
<td>2. What change(s) do you expect to make in this area by 6-30-82? _______</td>
</tr>
<tr>
<td>b) Development of effective monitoring systems to evaluate the quality and effectiveness of tuberculosis activities;</td>
<td>3. How can achievement of this objective be measured or demonstrated? ________________________</td>
</tr>
<tr>
<td>c) Consultation with physicians and others in the community;</td>
<td><strong>Process 2:</strong> By 19____ outpatient tuberculosis care services will be accessible to the community, and acute and long-term care facilities will be identified, accessible, and available.</td>
</tr>
<tr>
<td>d) Collection and analysis of surveillance assessment data;</td>
<td>1. Do you currently have such services and facilities which are accessible and available? ______ Yes ______ No</td>
</tr>
<tr>
<td>e) Coordination of overall tuberculosis control activities in the community, including recommendations on the allocation of resources.</td>
<td>2. What change(s) do you expect to make in this area by 6-30-82? _______</td>
</tr>
<tr>
<td><strong>Process 3:</strong> By 19____ at least 90 per cent of all patients for whom two or more drugs are recommended will complete their prescribed therapy.</td>
<td>3. How can achievement of this objective be measured or demonstrated? ________________________</td>
</tr>
<tr>
<td>___________</td>
<td>1. What per cent of all patients for whom two or more drugs are recommended currently will complete their prescribed therapy? _______</td>
</tr>
<tr>
<td></td>
<td>2. By what per cent will you increase the number of patients completing prescribed therapy by 6-30-82? ______</td>
</tr>
<tr>
<td></td>
<td>3. How can achievement of this objective be measured or demonstrated? ________________________</td>
</tr>
<tr>
<td><strong>Process 4:</strong> By 19____ at least 90 per cent of infected close contacts and other high-risk tuberculin-positive individuals will be placed on preventive therapy and will complete the recommended course of therapy.</td>
<td>1. What per cent of infected close contacts and other high-risk tuberculin-positive individuals are currently placed on preventive therapy and will complete the recommended course of therapy? _______</td>
</tr>
<tr>
<td>___________</td>
<td>2. By what per cent will you increase the proportion of infected close contacts and other high-risk tuberculin-positive individuals who are placed on preventive therapy and will complete the recommended course of therapy by 6-30-82? ______</td>
</tr>
<tr>
<td></td>
<td>3. How can achievement of this objective be measured or demonstrated? ________________________</td>
</tr>
</tbody>
</table>

(continued)
APPENDIX TABLE 1—(Continued)

Process 5: By 19_____ for close contacts of infectious cases, at least _____ per cent of those under 15 years of age will be placed on preventive therapy, regardless of tuberculin status, and will complete the recommended course of therapy.

1. What per cent of close contacts of infectious cases under 15 years of age are currently placed on preventive therapy, regardless of tuberculin status, and will complete the recommended course of therapy? 

2. By what per cent can you increase the proportion of close contacts of infectious cases under 15 years of age who are placed on preventive therapy, regardless of tuberculin status, and complete the recommended course of therapy by 6-30-82? 

3. How can achievement of this objective be measured or demonstrated?

APPENDIX TABLE 2—Number of Model Standards Outcome and Process Objectives per Program Negotiated

<table>
<thead>
<tr>
<th>Program</th>
<th>No. of Goal Statements</th>
<th>No. of Outcome Objectives</th>
<th>No. of Process Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization</td>
<td>1</td>
<td>1</td>
<td>6</td>
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Interamerican College of Physicians & Surgeons Seeks Participants

The Interamerican College of Physicians and Surgeons is seeking the participation of physicians and medical students who are interested in the development of closer relations with the physicians of the United States, Latin America, and Spain. The Interamerican group, currently representing over 18,000 Spanish-speaking physicians in the US and Puerto Rico, is forming a Post-Graduate Bilingual Faculty of Continued Medical Education to serve as a network of communication among medical schools, medical societies, health ministries, and individual physicians, "giving opportunities that enrich a society's human base for health and economic growth and democratic participation."

For further information, contact:

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