

MPROVE CORE MEASURES • NOVEMBER 2012

No.	Measure Name†	Type	Description
I. CHRONIC DISEASE PREVENTION DOMAIN (8 core measures, 3 optional measures)			
A. Tobacco Prevention and Control Bundle			
15	Smoking restriction policy exposure (<i>community</i>)	Reach	<p>Definition: Proportion of the population that resides in areas covered by policies that prohibit smoking in workplaces and other public areas during the past 12 months.</p> <p>Rationale: Tobacco exposure is the single largest source of preventable disease burden in the U.S. Smoking prevalence has stagnated at 40% among people age 18-25 years. Clean indoor air policies are the most effective known strategy (second only to tobacco taxes) for reducing exposure and related disease burden.</p> <p>Source: Data for this measure are available from Americans for Nonsmokers Rights, Public Health Law Research mapping study (www.no-smoke.org).</p> <p>Data: Because this measure does not require any PBRN data collection, we cannot claim it as an “MPROVE” measure per se. However, this measure is required for correct analysis and interpretation of Measure 16 below.</p>
16	Smoking restriction policy compliance and enforcement (<i>community</i>)	Volume	<p>Definition: Number of reported cases of clean indoor air policy violations in the community during the past 12 months; Number of compliance inspections/investigations conducted during the past 12 months; and number of citations/fines issued for violations.</p> <p>Rationale: Evidence indicates that clean indoor air policy compliance and enforcement varies widely across states and communities, possibly accounting for the two-fold differences in policy effectiveness observed across communities. NCI-funded research shows that gaps in compliance and enforcement disproportionately affect low-SES and racial/ethnic minority populations. Not all LHDs have the authority to investigate and enforce compliance directly; however, LHDs require data on compliance and enforcement in their jurisdiction in order to carry out their community health assessment, policy development, and assurance responsibilities effectively.</p> <p>Source: This measure is endorsed by International Agency for Research on Cancer, World Health Organization and has been found to have reasonable face validity (IARC Handbook of Cancer Prevention, Volume 12; 2012).</p> <p>Data: The measure requires data to be obtained from the records of the agency charged with compliance monitoring and enforcement. This agency varies across PBRN states (e.g. LHD, fire department, code enforcement).</p>
134/139	Agency involvement in tobacco prevention, control and cessation (<i>agency</i>)	Availability	<p>Definition: During the past 12 months, which of the following activities did your LHD help to perform related to tobacco prevention, control and cessation? Educational Materials; Educational Media; Cultural/Linguistic Specific Materials; Cultural/Linguistic Specific Programs; Educational/Training Programs; Community Development (i.e. coalitions); Policy Development; Tobacco Cessation Programs; adult tobacco use surveillance (e.g. BRFSS); youth tobacco use surveillance (e.g. YRBS). (assessment activities newly added)</p> <p>Rationale: Tobacco control activities that are endorsed and supported by LHDs may have greater visibility, reach, fidelity, coordination, targeting, and/or impact in the community. Assessment and surveillance activities are particularly important and particularly likely to be the responsibility of LHDs.</p> <p>Source: Colorado PBRN Baseline Capacity Assessment Instrument, modified based on Delphi Panel feedback.</p>

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			Data: The measure requires self-reported data from LHD personnel.
B. Obesity Prevention Bundle			
11	Combined physical activity intervention availability (<i>community</i>)	Availability	<p>Definition: Which of the following community-wide physical activity interventions have been underway within your jurisdiction during the past 12 months? (1) Community wide health education campaigns (e.g. large-scale, highly visible, messages directed to large audiences through media such as television, radio, and newspapers typically combined with other approaches including support or self-help groups, community events, or risk factor screenings.) (2) Community-wide stair use campaigns (e.g. motivational signs placed by elevators/escalators to encourage people to use nearby stairs for health/weight loss). (3) School-based PE programs (e.g. programs to increase amount of time students spend in PE classes which enhance the length or activity level of students and health education). (4) Social support interventions in community (e.g. focus on changing physical activity behavior through creating, strengthening and maintaining social networks that provide supportive relationships for behavior change). (5) Individually adapted health behavior change programs (e.g. teaching goal setting/self-monitoring of progress, structured problem solving & relapse prevention). (6) Initiatives to create or enhance access to places for physical activity combined with informational outreach activities e.g. (built environment-walking trails, biking trails, exercise facilities within worksites/coalitions, agencies). (7) Community-level urban design initiatives (e.g. developments to increase the % of residents living within walking distance of shopping, work, & school, improved connectivity of streets and sidewalks, preserve or create green-space & improve aesthetic qualities of the environment).</p> <p>Rationale: Obesity is the second leading source of preventable disease burden in the U.S. Access to physical activity interventions, resources, and supports have been shown to increase physical activity levels and reduce obesity risk – with the strongest evidence supporting interventions profiled in the CDC’s <i>Guide to Community Preventive Services</i>. The Affordable Care Act’s Prevention and Public Health Funded has recently expanded federal funding to support community-level obesity prevention activities. Recent surveillance data indicate that some communities are experiencing success with reducing overweight and obesity prevalence, particularly in children, but few studies have been able to link these community-level trends empirically to public health activities. One recent study has found an association between local public health activities for obesity prevention and community-level obesity prevalence (using crude measures of activity from NACCHO data), but more research is needed.</p> <p>Source: Validated survey instrument for use with local and state public health personnel: Ross Brownson Survey of Physical Activity Programs. <i>Am J Prev Med</i> 2007;33(15):S66–S78. The measure is based on activities profiled in the CDC <i>Guide to Community Preventive Services</i>. The measure is conditional on public health personnel awareness of community activities, which may itself be correlated with the intensity and/or reach of the activity, giving the measure face validity as a proxy for community-level intensity.</p> <p>Data: The measure requires self-reported data from LHD personnel.</p>
114	Agency involvement in physical activity promotion (<i>agency</i>)	Availability	<p>Definition: Was your LHD involved in an initiative to increase access to free or low cost recreational opportunities for physical activity (like working to develop policies to increase access to public facilities for physical activity, increasing worksites that have policies that enhance physical activity) in the last 12 months?</p>

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			<p>Rationale: Obesity prevention activities that are endorsed and supported by LHDs may have greater visibility, reach, fidelity, coordination, targeting, and/or impact in the community. This agency-level measure, used in combination with the community-level measure above, provides an indication of LHD contributions to community obesity prevention.</p> <p>Source: Washington Public Health Activities and Services Inventory. Not a validated measure but an experience-tested measure.</p> <p>Data: The measure requires self-reported data from LHD personnel. This measure could be linked directly with the community-level measure #11: For each item in #11 marked as yes, ask whether LHD is involved.</p>
13	Agency funding for physical activity promotion (<i>agency</i>)	Capacity	<p>Definition: How much funding did your department allocate for physical activity promotion during the most recently completed fiscal year?</p> <p>Rationale: Obesity prevention activities that are endorsed and supported by LHDs may have greater visibility, reach, fidelity, coordination, targeting, and/or impact in the community. This measure may serve as a proxy indicator for intensity of activity.</p> <p>Source: Validated survey instrument for use with local and state public health personnel: Ross Brownson Survey of Physical Activity Programs. Am J Prev Med 2007;33(1S):S66–S78</p> <p>Data: The measure requires self-reported data from LHD personnel.</p>
75	Agency involvement in increasing access to healthy foods (<i>agency</i>)	Availability	<p>Definition: Was your LHD involved in an initiative to increase access to healthy foods in the community in the past 12 months?</p> <p>Rationale: Obesity prevention activities that are endorsed and supported by LHDs may have greater visibility, reach, fidelity, coordination, targeting, and/or impact in the community. This agency-level measure, used in combination with the community-level measure above, provides an indication of LHD contributions to community obesity prevention.</p> <p>Source: Washington Public Health Activities and Services Inventory. Not a validated measure but an experience-tested measure.</p> <p>Data: The measure requires self-reported data from LHD personnel.</p>
78	FTE personnel dedicated to increasing access to healthy foods (<i>agency</i>)	Capacity	<p>Definition: Number of LHD FTE personnel dedicated to increasing access to healthy foods during the past 12 months.</p> <p>Rationale: Obesity prevention activities that are endorsed and supported by LHDs may have greater visibility, reach, fidelity, coordination, targeting, and/or impact in the community.</p> <p>Source: Washington Public Health Activities and Services Inventory. Not a validated measure but an experience-tested measure.</p>

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			Data: The measure requires self-reported data from LHD personnel.
C. Oral Health Bundle (optional given that nationally only 27% of LHDs offer oral health programs directly or by contract)			
109	Oral health screening (<i>agency</i>)	Volume	<p>Definition: Number of individuals who were screened by the LHD for dental/oral health conditions during the past 12 months</p> <p>Rationale: Dental caries is among the most prevalent preventable health conditions in the U.S., particularly among children. The health and economic burden of oral health conditions is considerable. LHD-provided oral health services generally target population groups who lack access to mainstream dental services providers and therefore are most at risk for experiencing preventable disease burden.</p> <p>Source: New Jersey PBRN has pilot tested this measure.</p> <p>Data: The measure requires data to be obtained from the administrative records of the LHDs providing the screening.</p>
110	Oral health prevention and promotion (<i>agency</i>)	Availability	<p>Definition: Which of the following oral health prevention and promotion activities have been provided by your LPHA over the past 12 months: Educational Materials; Educational Media; Cultural/Linguistic Specific Materials; Cultural/Linguistic Specific Programs; Educational/Training Programs; Community Development (i.e. coalitions); Policy Development; Oral Health Screening. Identify who delivered the service with 3 = LPHA; 2 = Another Agency; 1 = Needed, but not available; 0 = Not applicable.</p> <p>Rationale: Oral health prevention and promotion activities that are endorsed and supported by LHDs may have greater visibility, reach, fidelity, coordination, targeting, and/or impact in the community.</p> <p>Source: Colorado PBRN Baseline Capacity Assessment Instrument, modified based on Delphi Panel feedback.</p> <p>Data: The measure requires self-reported data from LHD personnel.</p>

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II. COMMUNICABLE DISEASE CONTROL DOMAIN (14 core measures)			
A. Immunization Bundle			
153	Childhood immunization completeness (<i>community</i>)	Reach	<p>Definition: Proportion of children vaccinated with complete series as required by state law upon entry into kindergarten for the most recent school year.</p> <p>Rationale: Although statewide vaccination rates at kindergarten entry are at or above target levels nationally and at state levels, local areas of low coverage exist and present significant population health risks. The growing use of religious and philosophical exemptions to school vaccination requirements in recent years has added to these risks. Actions of public health agencies and their community partners can address these risks through education and outreach, policy development, and direct service delivery.</p> <p>Source: Immunization Services Division, National Center for Immunization and Respiratory Diseases, CDC. MMWR 2012 / 61(33);647-652.</p> <p>Data: The measure requires data to be obtained from the administrative records or surveillance systems of the LHDs and/or SHAs participating in the PBRN.</p>
154/160	Childhood immunizations administered by agency (<i>agency</i>)	Volume	<p>Definition: Number of immunizations administered by the LHD to children 0-5 years, and children 6-18 years, during the past 12 months. [Age-specific population estimates will be used to construct per capita volume measures]</p> <p>Rationale: In combination with the community level immunization measure, this measure provides an indication of the agency contribution to community-level vaccination coverage.</p> <p>Source: New Jersey PBRN; measures have been pilot tested.</p> <p>Data: The measure requires data to be obtained from the administrative records or surveillance systems of the LHDs and/or SHAs participating in the PBRN.</p>
201	Confirmed vaccine-preventable disease cases (<i>community</i>)	Volume	<p>Definition: Number of confirmed vaccine-preventable disease cases in the past 12 months (cases of rubella, measles, congenital rubella, mumps, tetanus), by vaccination status if possible. [Population estimates will be used to construct case rate measure].</p> <p>Rationale: Outbreaks of vaccine-preventable diseases represent significant sources of preventable disease burden, particularly for under-served and vulnerable population groups. Actions of public health agencies and their community partners can address these risks through education and outreach, policy development, and direct service delivery.</p> <p>Source: Immunization Services Division, National Center for Immunization and Respiratory Diseases, CDC.</p> <p>Data: The measure requires data to be obtained from state or local public health surveillance systems for reportable diseases.</p>
B. Enteric Disease Bundle			
167	Foodborne/Waterborne reported case volume	Volume	<p>Definition: Number of reported cases of enteric disease in the past 12 months. A case indicates that the patient</p>

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	<i>(community)</i>		<p>resides in the agency's jurisdiction and the reported case was first received by the agency during the 12 month period. Foodborne / Waterborne Diseases = sum of all reported cases of the following: E. coli, shiga toxin producing strains only; Salmonellosis; Campylobacteriosis; Shigellosis; Ciguatera; Paralytic shellfish poisoning; Scombroid mushroom poisoning; Botulism. [Population estimates will be used to construct case rate measure].</p> <p>Rationale: Foodborne and waterborne diseases are significant sources of preventable morbidity, health care utilization, and lost time from work and school. Public health actions can reduce the risks, magnitude, and duration of these outbreaks.</p> <p>Source: New Jersey PBRN; measure has been pilot tested.</p> <p>Data: The measure requires data to be obtained from state or local public health surveillance systems for reportable diseases.</p>
165	Foodborne/Waterborne confirmed case volume <i>(community)</i>	Volume	<p>Definition: Number of confirmed cases of enteric disease in the past 12 months. A case indicates that the patient resides in the agency's jurisdiction and the reported case was confirmed by the agency during the 12 month period. Foodborne / Waterborne Diseases = sum of all reported cases of the following: E. coli, shiga toxin producing strains only; Salmonellosis; Campylobacteriosis; Shigellosis; Ciguatera; Paralytic shellfish poisoning; Scombroid mushroom poisoning; Botulism based on CDC case classification guidelines for each disease. [Population estimates will be used to construct case rate measure].</p> <p>Rationale: Foodborne and waterborne diseases are significant sources of preventable morbidity, health care utilization, and lost time from work and school. Public health actions can reduce the risks, magnitude, and duration of these outbreaks.</p> <p>Source: New Jersey PBRN; measure has been pilot tested.</p> <p>Data: The measure requires data to be obtained from state or local public health surveillance systems for reportable diseases.</p>
162	Foodborne enteric investigation volume <i>(agency)</i>	Volume	<p>Definition: Number of investigations of reported foodborne/enteric disease cases conducted by LHD during the past 12 months. [Measure #167 will be used as denominator to construct investigation rate measure].</p> <p>Rationale: Foodborne and waterborne diseases are significant sources of preventable morbidity, health care utilization, and lost time from work and school. Public health actions can reduce the risks, magnitude, and duration of these outbreaks.</p> <p>Source: New Jersey PBRN; measure has been pilot tested.</p> <p>Data: The measure requires data to be obtained from state or local public health surveillance systems for reportable diseases.</p>
164	Foodborne enteric investigation completion time <i>(agency)</i>	Quality-timeliness	<p>Definition: Average time from receipt of reported case of enteric disease to completion of case investigation, for all cases received in past 12 months.</p>

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			<p>Rationale: Foodborne and waterborne diseases are significant sources of preventable morbidity, health care utilization, and lost time from work and school. Public health actions can reduce the risks, magnitude, and duration of these outbreaks. Timely investigation of foodborne diseases is necessary to identify persons at risk for exposure and to prevent additional cases in outbreak settings.</p> <p>Source: Hedberg CW, Greenblatt JF, Matyas BT, Lemmings J, Sharp DJ, Skibicki RT, et al. Timeliness of enteric disease surveillance in 6 US states. <i>Emerg Infect Dis.</i> 2008 Feb. http://wwwnc.cdc.gov/eid/article/14/2/07-0666.htm</p> <p>Data: The measure requires data to be obtained from state or local public health electronic disease surveillance systems for reportable diseases.</p>
C. Sexually Transmitted Infection Control Bundle			
184	STI cases confirmed (<i>community</i>)	Volume	<p>Definition: Number of confirmed sexually transmitted disease cases, by type if possible (gonorrhea, chlamydia, syphilis, HIV). [Population estimates will be used to construct case rate measures].</p> <p>Rationale: More than 20 million new infections occur in the U.S. each year, generating >\$20 billion in health care costs annually. Undetected and untreated STDs can elevate risk for HIV and cause other serious health consequences, such as infertility. STD screening and contact tracing can help detect disease early and, when combined with treatment, are among the most effective tools available to protect health and prevent disease spread. Nationally, less than half of populations at risk are screened appropriately for STIs. Nationally, 92% of LHDs conduct communicable disease surveillance, 64% provide STI screening, and 59% provide STI treatment.</p> <p>Source: New Jersey PBRN, and Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Division of STD Prevention. Case rates are subject to surveillance bias, so areas with low access to screening and low screening rates may falsely appear to have low rates of disease.</p> <p>Data: The measure requires data to be obtained from state or local public health electronic disease surveillance systems for reportable diseases.</p>
181	STI contact tracing (<i>agency</i>)	Volume	<p>Definition: Number of STI contacts followed by the LHD in the past 12 months, by type if possible (gonorrhea, chlamydia, syphilis, HIV). [Volume measure from #184 will be used to construct a measure of the case tracing rate.]</p> <p>Rationale: STD screening and contact tracing can help detect disease early and, when combined with treatment, are among the most effective tools available to protect health and prevent disease spread. Nationally, less than half of populations at risk are screened appropriately for STIs. Nationally, 92% of LHDs conduct communicable disease surveillance, 64% provide STI screening, and 59% provide STI treatment.</p> <p>Source: Washington Public Health Activities and Services Inventory.</p> <p>Data: The measure requires data to be obtained from state or local public health electronic disease surveillance systems for reportable diseases.</p>
204	STI staffing level (<i>agency</i>)	Capacity	<p>Definition: Current FTE staffing level for disease intervention specialists (DIS) at the LHD: individuals employed</p>

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			<p>by a local public health authority who are trained to provide components of STI case management and control services, including client interviewing, partner notification and referral, untreated patient referral, education activities and consultation for individuals diagnosed with an STI.</p> <p>Rationale: STD screening and contact tracing can help detect disease early and, when combined with treatment, are among the most effective tools available to protect health and prevent disease spread. Nationally, less than half of populations at risk are screened appropriately for STIs. Nationally, 92% of LHDs conduct communicable disease surveillance, 64% provide STI screening, and 59% provide STI treatment.</p> <p>Source: North Carolina PBRN and CDC's Program Operations Guidelines for STD Prevention.</p> <p>Data: The measure requires data to be obtained from state or local public health program records.</p>
D. Tuberculosis Control Bundle			
195	TB case volume (<i>community</i>)	Volume	<p>Definition: Number of reported tuberculosis cases in the past 12 months. [Population estimates will be used to construct case rate measures].</p> <p>Rationale: Although U.S. active TB case rates are at their lowest recorded rates in history, these rates vary widely across states and TB remains a source of considerable preventable health and economic burden. Timely contact tracing, screening, and treatment can contain the spread of disease.</p> <p>Source: New Jersey PBRN and CDC Division of TB Elimination, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. MMWR March 23, 2012 / 61(11);181-185.</p> <p>Data: The measure requires data to be obtained from state or local public health electronic disease surveillance systems for reportable diseases.</p>
196	TB active contact screening (<i>agency</i>)	Volume	<p>Definition: Number of unduplicated clients that were provided active TB contact screening services by the LHD during the past 12 months. [Volume measure #195 will be used to construct contact screening rate]</p> <p>Rationale: Although U.S. active TB case rates are at their lowest recorded rates in history, these rates vary widely across states and TB remains a source of considerable preventable health and economic burden. Timely contact tracing, screening, and treatment can contain the spread of disease.</p> <p>Source: New Jersey PBRN and CDC Division of TB Elimination, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. MMWR March 23, 2012 / 61(11);181-185.</p> <p>Data: The measure requires data to be obtained from state or local public health program records.</p>
193	TB therapy (<i>agency</i>)	Quality-fidelity	<p>Definition: Percentage of TB cases that were placed on directly observed therapy in the past 12 months.</p> <p>Rationale: Although U.S. active TB case rates are at their lowest recorded rates in history, these rates vary widely across states and TB remains a source of considerable preventable health and economic burden. Timely contact tracing, screening, and treatment can contain the spread of disease.</p> <p>Source: New Jersey PBRN and CDC Division of TB Elimination, National Center for HIV/AIDS, Viral Hepatitis, STD,</p>

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			and TB Prevention. MMWR March 23, 2012 / 61(11);181-185. Data: The measure requires data to be obtained from state or local public health program records..
199	TB contacts who completed treatment for latent tb (<i>agency</i>)	Quality-fidelity	Definition: Percentage of contacts with newly-diagnosed latent TB infection who (1) started and (2) completed treatment in the past 12 months. Rationale: Although U.S. active TB case rates are at their lowest recorded rates in history, these rates vary widely across states and TB remains a source of considerable preventable health and economic burden. Timely contact tracing, screening, and treatment can contain the spread of disease. Source: New Jersey PBRN and CDC Division of TB Elimination, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. MMWR March 23, 2012 / 61(11);181-185. Data: The measure requires data to be obtained from state or local public health program records.
III. ENVIRONMENTAL HEALTH PROTECTION DOMAIN (5 core measures and 3 optional measures)			
A. Lead Protection Bundle			
219	Elevated blood lead level rate (<i>community</i>)	Quality-effectiveness	Definition: Number of cases of elevated blood lead in children ages 0-6 years identified in the past 12 months, per 1000 children age 0-6 years. Specify blood lead level threshold used to define elevated blood lead level. [Population estimates will be used to construct case rate measure]. Rationale: Children's blood lead levels continue to decline in the United States, even in historically high-risk groups for lead poisoning. To maintain progress made and eliminate remaining disparities, efforts must continue to test children at high risk for lead poisoning, and identify and control sources of lead. Coordinated prevention strategies at local levels have been shown highly effective in reducing elevated blood lead levels. In 2012 CDC lowered its blood lead level criteria, which is likely to precipitate changes to case detection and investigation rates and practices. Source: Tennessee and New Jersey PBRNs. Data: The measure requires data to be obtained from state or local public health disease surveillance systems for reportable diseases.
220	Elevated blood lead level investigation (<i>agency</i>)	Volume	Definition: Number of cases of elevated blood lead (EBL) in children age 0-6 years investigated by the LHD in the past 12 months (to be expressed as a proportion of measure #219). [Measure #219 will be used to construct a measure of the investigation rate] Rationale: Children's blood lead levels continue to decline in the United States, even in historically high-risk groups for lead poisoning. To maintain progress made and eliminate remaining disparities, efforts must continue to test children at high risk for lead poisoning, and identify and control sources of lead. Coordinated prevention strategies at local levels have been shown highly effective in reducing elevated blood lead levels. In 2012 CDC lowered its blood lead level criteria, which is likely to precipitate changes to case detection and investigation rates and practices.

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			<p>Source: Tennessee and New Jersey PBRNs.</p> <p>Data: The measure requires data to be obtained from state or local public health disease surveillance systems for reportable diseases.</p>
B. Food Protection Bundle			
236a	Food safety inspection reach (<i>community</i>)	Reach	<p>Definition: Number of (a) food service establishments inspected for food safety during the past 12 months, as a percentage of (b) the total number of food service establishments required to be inspected under state and/or local law.</p> <p>Rationale: Foodborne diseases are significant sources of preventable morbidity, health care utilization, and lost time from work and school. Public health actions can reduce the risks, magnitude, and duration of these outbreaks. Nationally, more than 90% of LHDs perform food service establishment inspection and mitigation activities.</p> <p>Source: Massachusetts PBRN Survey Instrument; Tennessee PBRN (TN Department of Health Electronic Environmental Health Database).</p> <p>Data: The measure requires data to be obtained from administrative records on inspections maintained by local or state public health agencies.</p>
236b	Food safety inspection volume (<i>community</i>)	Volume	<p>Definition: Number of inspections of food service establishments conducted during the past 12 months.</p> <p>Rationale: Foodborne diseases are significant sources of preventable morbidity, health care utilization, and lost time from work and school. Public health actions can reduce the risks, magnitude, and duration of these outbreaks. Nationally, more than 90% of LHDs perform food service establishment inspection and mitigation activities.</p> <p>Source: Massachusetts PBRN Survey Instrument; Tennessee PBRN (TN Department of Health Electronic Environmental Health Database).</p> <p>Data: The measure requires data to be obtained from administrative records on inspections maintained by local or state public health agencies.</p>
233	Food safety field staffing ratio (<i>community</i>)	Capacity	<p>Definition: Number of FTE personnel devoted to retail food safety inspection, protection and control activities per 100 retail food services establishments during the past 12 months. "Inspections for purposes of this calculation include routine inspection, re-inspection, complaint investigations, outbreak investigations, compliance follow-up inspections, risk assessment reviews, process reviews, variance process reviews and other direct establishment contact time such as on-site training."</p> <p>Rationale: Foodborne diseases are significant sources of preventable morbidity, health care utilization, and lost time from work and school. Public health actions can reduce the risks, magnitude, and duration of these outbreaks. Nationally, more than 90% of LHDs perform food service establishment inspection and mitigation activities.</p>

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			<p>Source: FDA Voluntary National Retail Food Regulatory Program Standards (Standard #8) http://www.fda.gov/Food/FoodSafety/RetailFoodProtection/ProgramStandards/ucm125049.htm</p> <p>Data: The measure requires data to be obtained from administrative/personnel records maintained by local or state public health agencies charged with retail food safety inspection activities.</p>
<p>C. Water System Protection Bundle (optional given that only 35% of LHDs nationally are involved in public water system inspection/protection)</p>			
272a	Public water system reach (<i>community</i>)	Reach	<p>Definition: Percentage of the population served by public water systems during the past 12 months.</p> <p>Rationale: Access to clean, safe, and affordable drinking water remains a concern for many rural and underserved populations in the U.S., particularly those that rely on private water systems that are vulnerable to environmental contamination due to proximate agricultural, industrial, mining, and solid waste disposal activities. Access to flouridated water to improve oral health is also limited for these populations.</p> <p>Source: North Carolina PBRN (state Division of Public Health, Environmental Health Branch)</p> <p>Data: The measure requires data to be obtained from administrative records maintained by local or state public health agencies and/or corresponding water authorities.</p>
273	Public water system inspection volume (<i>community</i>)	Volume	<p>Definition: Number of drinking water samples from public water systems submitted and evaluated for public health protection in the past 12 months</p> <p>Rationale: Access to clean, safe, and affordable drinking water remains a concern for many rural and underserved populations in the U.S. Public water systems can be vulnerable to environmental contamination due to proximate agricultural, industrial, mining, and solid waste disposal activities.</p> <p>Source: Washington PBRN Public Health Activities and Services Tracking System</p> <p>Data: The measure requires data to be obtained from administrative records maintained by local or state public health agencies and/or corresponding water authorities.</p>
272b	Exposure to public water system contamination (<i>community</i>)	Quality	<p>Definition: Percentage of population being served by public water systems with no maximum contamination level violations during the past 12 months.</p> <p>Rationale: Access to clean, safe, and affordable drinking water remains a concern for many rural and underserved populations in the U.S. Public water systems can be vulnerable to environmental contamination due to proximate agricultural, industrial, mining, and solid waste disposal activities.</p> <p>Source: North Carolina PBRN (state Division of Public Health, Environmental Health Branch)</p> <p>Data: The measure requires data to be obtained from administrative records maintained by local or state public health agencies and/or corresponding water authorities.</p>

†NOTE: The label *community* in the measure name column indicates a community-level measure that is intended to capture all services/activities performed in the community, regardless of which entity or entities perform the action. The label *agency* in the measure name column indicates an agency-level measure that is intended to capture the services/activities performed directly by the local health department in the community.